Premier PHYSICAL THERAPY

Past Medical History Form

Patient Name _____ Date _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: _____

Date of Injury/Surgery: _____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your current condition:

☐ Work-related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other _____
☐ Cause unknown ☐ Athletic / recreational injury

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest pain / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Nausea / Vomiting	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Ringing in your ears	☐	☐
Urine leakage	☐	☐	Rheumatoid Arthitis	☐	☐
Asthma / Breathing Difficulties	☐	☐	Stroke / CVA	☐	☐
Liver / Gallbladder Problems	☐	☐	Hypoglycemia	☐	☐
Smoking	☐	☐	Depression	☐	☐
Other _____	☐	☐	Anxiety	☐	☐

If yes on any of the above, please briefly explain and give approximate dates

_____

_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

List current medications (prescriptions, over the counter, herbals, vitamin/mineral/dietary supplements) including name, dosages, frequency and route.

_____

_____

_____

_____

_____

_____

_____

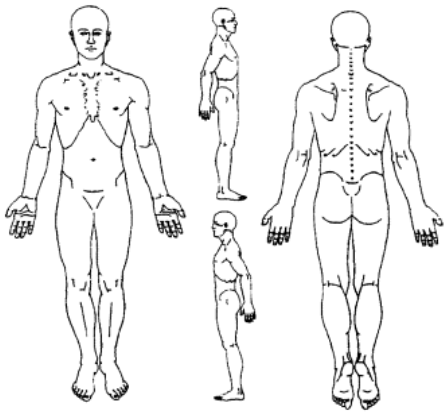
In the rare instance of an emergency whom should we contact?

Name_____

Phone( )_____

Do you participate in any sports, exercise programs or activities on a regular basis? □ Yes □ No

Please indicate on the picture below where your symptoms are located:



Numeric Pain Rating Scale

1. How would you rate your pain RIGHT NOW.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

2. How would you rate your USUAL level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

3. How would you rate your BEST level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

4. How would you rate your WORST level of pain during the last week.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Worst Pain Imaginable

_____ _____ _____ _____

Patient's Signature Date Signature of Guardian if patient is a minor Date

_____ _____

Therapist Signature Date