PEAK
PHYSICAL
THERAPY

PATIENT MEDICAL HISTORY

NAME_____DATE_____

REFERRING PHYSICIAN_____PRIMARY CARE PHYSICIAN_____

REASON FOR SEEKING TREATMENT (INJURY DESCRIPTION)_____

_____

DATE OF ONSET AND OR SURGERY_____

MEDICATIONS (LIST)

1)_____FOR_____

2)_____ FOR_____

3)_____ FOR_____

4)_____FOR_____

5)_____FOR_____

OTHERS_____

MEDICAL HISTORY (CIRCLE BELOW YES OR NO, INDICATE DATE IF SURGERY)

DIABETES	Y	N	RHEUMATOID ARTHRITIS	Y	N
HIGH BLOOD PRESSURE	Y	N	OSTEOARTHRITIS	Y	N
HEART ATTACK	Y	N	OSTEOPOROSIS	Y	N
HEART SURGERY	Y	N	METAL IMPLANTS/WHERE	Y	N
PACEMAKER	Y	N	METAL SCREWS/PINS/PLATES	Y	N
SHORTNESS OF BREATH	Y	N	SPINE FUSIONS	Y	N
CHEST PAIN	Y	N	JOINT REPLACEMENTS/WHERE	Y	N
CANCER HX/LOCATION	Y	N	NECK SURGERY	Y	N
CHEMOTHERAPY	Y	N	BACK SURGERY	Y	N
ASTHMA	Y	N	HIP SURGERY	Y	N
RESPIRATORY DISEASE	Y	N	KNEE SURGERY	Y	N
STROKE	Y	N	ANKLE SURGERY	Y	N
BLOOD CLOT/LOCATION	Y	N	SHOULDER SURGERY	Y	N
SEIZURES/EPILEPSY	Y	N	ELBOW SURGERY	Y	N
CATARACTS	Y	N	SMOKING	Y	N
VISION PROBLEMS	Y	N	KIDNEY DISEASE/STONES	Y	N
HEARING PROBLEMS	Y	N	ULCERS	Y	N
DIZZINESS	Y	N	LIST OTHER SURGERIES_____		
PREGNANT	Y	N	_____		
FRACTURES/WHERE	Y	N	_____		
HERNIA	Y	N	_____		
WEAKNESS	Y	N	_____		

PEAK
PHYSICAL
THERAPY

CURRENT PROBLEM: DO YOU EXPERIENCE ANY OF THE FOLLOWING? (CIRCLE)

NAUSEA	Y N	NUMBNESS/TINGLING	Y N
VOMITTING	Y N	BOWEL OR BLADDER CHANGES	Y N
FEVER/CHILLS/SWEATS	Y N	NIGHT PAIN	Y N
SUDDEN WEIGHT GAIN/LOSS	Y N	HEADACHES	Y N

LIST REGULAR EXERCISE/ACTIVITY

_____

_____

_____

PAST TREATMENT FOR PROBLEM YOU ARE SEEKING TREATMENT FOR TODAY

ORTHOPEDIST	Y N	ACUPUNCTURE	Y N
NEUROSURGEON	Y N	PSYCHOLOGIST	Y N
CHIROPRACTOR	Y N	OTHER PHYSICAL THERAPIST	Y N
MASSAGE THERAPIST	Y N	OTHER_____	

DESCRIBE/LIST HOW PROBLEM INTERFERES WITH DAILY ACTIVITY (WORK, SPORT, ACTIVITIES)

_____

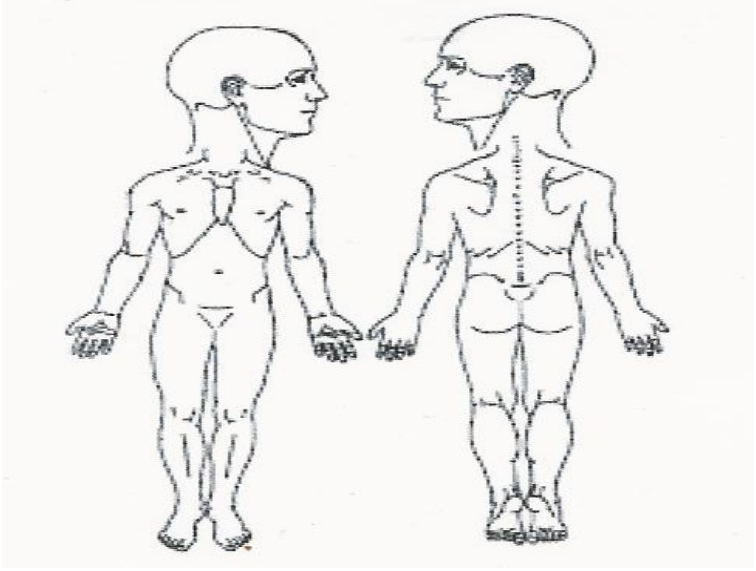
_____

_____

_____

USING DIAGRAM BELOW DRAW X('s) WHERE PAIN IS AND INDICATE PAIN LEVEL ON SCALE OF 1-10,(10=WORST PAIN)

(Short Form McGill Pain Pain Diagram)



By signing below I attest the information provided above is true and accurate to the best of my knowledge.

Patient Signature X_____