



PHYSICAL THERAPY & HAND CENTERS, INC.

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____

Age: _____ Referred by: _____

DATE OF INJURY: _____ DATE OF SURGERY: _____

Briefly describe the history of your present condition / problem to be treated:

On a scale of 0 to 10, how much pain/discomfort are you in? (fill bubble) low high
0 1 2 3 4 5 6 7 8 9 10
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Have you ever had physical therapy before? Yes No

Have you received treatment for this problem before? Yes No If yes, please explain below:

Have you had surgery for this condition? Yes No

Are you presently taking any medication? Yes No If yes, please list below:

Do you have or have ever had any of the following:

- Diabetes Yes No
- High Blood Pressure Yes No
- Heart Disease Yes No
- Headaches Yes No
- Kidney Problems Yes No
- Nervous Disorders Yes No
- Circulation Problems Yes No
- Back or Neck Pain Yes No
- Stress Yes No
- Sensitive to Heat/Ice Yes No
- Allergies Yes No
- Hernia Yes No
- Broken Bones Yes No
- Sprained Joints Yes No
- Seizures Yes No
- Dizzy Spells Yes No
- Muscle Aches/Pain Yes No

- Do you have a pacemaker? Yes No
- Do you have any metal implants? Yes No
- Are you pregnant? Yes No
- Do you have trouble with vision? Yes No
- Do you have trouble with hearing? Yes No
- Do you have trouble with balance? Yes No
- Have you ever been diagnosed with cancer? Yes No
- Have you ever had a heart attack? Yes No

Please explain any Yes answers below:

Please list any other major illness, or surgery that has occurred in the past year:

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____