Diamondback Physical Therapy

Medical Form

Date: _____

Patient Name: _____ Date of birth: _____ Age: ____
Are you presently working? ___Yes ___No Next Dr. Visit: _____
Diagnosis/chief complaint: _____

1. Date of injury/onset: _____ 2. Have you ever had these symptoms before? ___Yes ___No

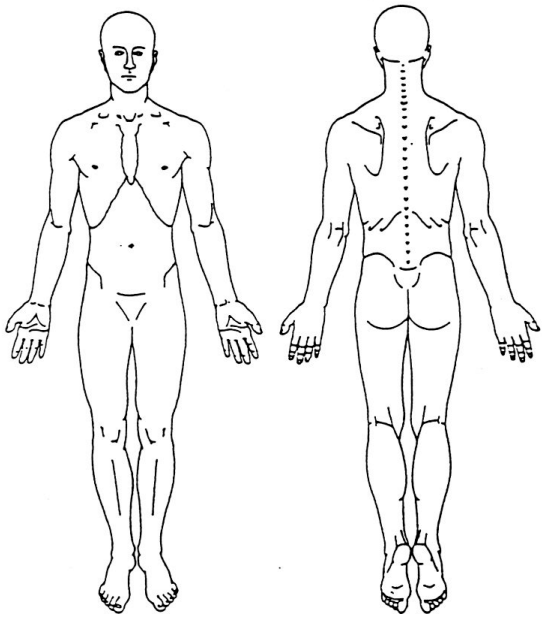
3. Check which apply to your current condition:

Motor Vehicle Accident	**Work Related**	**Recurrence of previous injury**
Cause unknown	**Injury related to lifting**	**Athletic/Recreational**
Injury related to falling	**Two or more falls in the last year**	**Other: _____**

4. Have you had a related surgery? ___Yes ___No Date: _____
5. Have you had any surgeries? ___ Yes ___ No
Explain:_____

6. If female, are you pregnant? ___Yes ___No

7. Please indicate below where your symptoms are located:



KEY:

Numbness: XXXXXXXXX

Pins & Needles: ooooooooo

Burning Pain: ////////////////////

Stabbing Pain: +++++++++

8. Please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible:
Pain at best: __ /10 Pain at worst: __/10

9. How and when did your injury occur or how and when did your symptoms begin: _____

_____

_____

_____

Past Medical History Form

9. Do you participate in any sports, exercise programs or activities on a regular basis? ___Yes ___No

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

HEART DISEASE

Congestive Heart Failure	___Yes ___No	Valvular Disease	___Yes ___No
High Blood Pressure	___Yes ___No	Stents	___Yes ___No
Heart Attack	___Yes ___No	Arrhythmia	___Yes ___No
Atherosclerotic Disease	___Yes ___No	Coronary Artery Bypass Graft	___Yes ___No
Angioplasty	___Yes ___No	Angina	___Yes ___No
Pacemaker	___Yes ___No		

LUNG DISEASE

Chronic Obstructive Pulmonary Disease:		Asthma	___Yes ___No
	___Yes ___No	Recent Pneumonia	___Yes ___No
Emphysema	___Yes ___No		

VASCULAR DISEASE

Peripheral Arterial Disease	___Yes ___No	Stroke/TIA	___Yes ___No
Diabetes	___Yes ___No	Chronic Bronchitis	___Yes ___No
Taking Blood Pressure Meds	___Yes ___No	Hypertension	___Yes ___No
Acquired Respiratory Distress Syndrome :			
	___Yes ___No		

GENERAL MEDICAL CONDITIONS

Rheumatoid Arthritis	___Yes ___No	Degenerative Disc Disease	___Yes ___No
Osteoarthritis	___Yes ___No	Hepatitis/AIDS	___Yes ___No
Allergies	___Yes ___No	Prior Surgery	___Yes ___No
Neurological Disease	___Yes ___No	Osteoporosis	___Yes ___No
Headaches	___Yes ___No	Anxiety	___Yes ___No
Gastrointestinal Disease	___Yes ___No	Panic Disorder	___Yes ___No
Hernia	___Yes ___No	Depression	___Yes ___No
Ulcer	___Yes ___No	Previous Accidents	___Yes ___No
Reflux Problems	___Yes ___No	Kidney Problems	___Yes ___No
Bowel Abnormalities	___Yes ___No	Prostrate Problems	___Yes ___No
Liver Problems	___Yes ___No	Incontinence	___Yes ___No
Gall Bladder Problems	___Yes ___No	Hearing Impairment	___Yes ___No
Cataracts	___Yes ___No	Sleep Dysfunction	___Yes ___No
Glaucoma	___Yes ___No	Prosthesis Implants	___Yes ___No
Macular Degeneration	___Yes ___No	Cancer	___Yes ___No
Hypoglycemia	___Yes ___No	Seizures	___Yes ___No
Stroke	___Yes ___No	Metal Implants	___Yes ___No
Skin Abnormalities	___Yes ___No	Dizziness/Fainting	___Yes ___No
Smoking	___Yes ___No	Fracture	___Yes ___No

If you said yes to any of the above items, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

11. Do you have any allergies?: ___Yes ___No

If yes, please list:

_____

_____

12. Are you currently taking any medication?: ___Yes ___No

If yes, please list what medication, dosage, and related condition:

_____

_____

_____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____