Cocozzo Physical Therapy

Accelerate Your Functional Movement

PATIENT MEDICAL HISTORY FORM

Patient:_______________________________________ Date:_________________________

1. What is your primary problem?____
2. Do you have any secondary problems?____
3. How did your problem begin?____
____
4. When did your problem begin?____
5. Have you had surgery for your condition?____
6. Have you had any diagnostic tests (i.e. XRays, MRI, EMG, etc.)? Please list date/location/results
____
7. Have you had anything similar before? NO____ YES____ If yes, tell me about it:______________________
____
8. What is your occupation/hobby?____
9. Are you working? YES____ NO____ If no, is it because of your problem? YES____ NO_____
10. What job duties do you perform?____
11. Are you on restricted duty? YES_____ NO_____
12. Just prior to this onset, were you completely free of symptoms? YES____ NO____

Have you ever had any of the following conditions? Please explain all YES answers in the space provided below:

	YES	NO		YES	NO
ASTHMA			GOUT		
CANCER			OPEN HEART SURGERY		
DIABETES			ARTHRITIS		
HEART DISEASE			TUBERCULOSIS		
HEPATITIS			FRACTURES		
HIGH BLOOD PRESSURE			EPILEPSY/SEIZURES		
SKIN CONDITIONS			DISLOCATIONS/JOINT PROBLEMS		
STROKE			PACEMAKER		
THYROID PROBLEM			OTHER HEALTH PROBLEMS		

Please explain all YES answers:____
____
____
____

Do you have any allergies? NO____ YES____ If yes, please list:_____________________________________
____

Please list any hospitalizations/surgeries:____
____

Women Only: Are you pregnant? NO______ YES_____

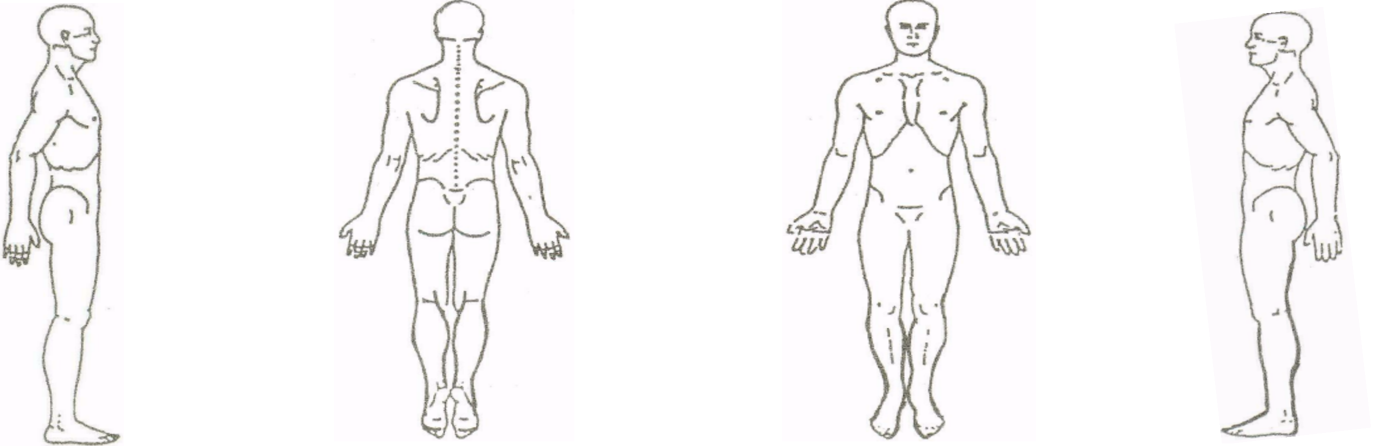
Hand Dominance Left Right

Height:________________ Weight:_______________

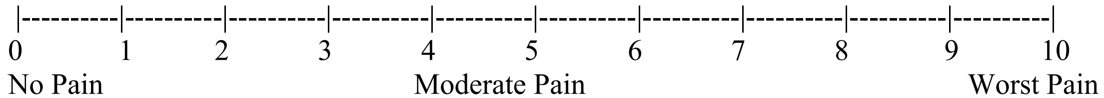
PATIENT MEDICAL HISTORY FORM (Continued)

Are you taking any medications presently? NO_____ YES_____ If so, please list:________________________________
____
____

13. Describe the nature of your problem and indicate on diagram where: ______________________________________
____
____
____



Please indicate your CURRENT pain level on the chart below:



14. What if any treatments have you had for this current problem? ____
____
____

Did they help? Yes____ No____

15. What in particular makes your pain worse? ____
____
16. What, if anything, eases the pain? ____
17. Can you get comfortable at night? Yes___ No___
18. How do you feel upon rising? Stiff___ Sore___ Fine___
19. Once you start moving about, does it worsen____ or ease____?
20. What is it like at the end of the day? Worse___ Easier____
21. Do you have any pins and needles, etc? Yes___ No___ (if yes, please indicate location on diagram above)
22. At this time, do you consider you are getting better___, worse___ or stable___?

Please rate your ability to perform the following activities:
1-Not Limited 2-Can do with some difficulty 3-Can do with significant difficulty 4-Can't do at all

Sleeping___ Dressing___ Sitting___ Standing___ Walking___ Housework___
Driving___ Stairs___ Sporting Activities___ Sexual Activity___ Yardwork___

WHAT GOALS DO YOU WANT TO ACHIEVE WITH THERAPY?_______________________________
____
____

Patient Signature:____________________________________ Date:__________________________________