REVOLUTION PHYSICAL THERAPY NYC

PATIENT MEDICAL HISTORY FORM

Name: ______________________________ Treating Physician: ____________________

Family Physician: ____________________ Date of 1st Doctors Visit For this Injury: ________

Last Day Worked Due to this Injury: ______________ Date Returned to Work After Injury: __________

Is an attorney involved in this case? YES NO Were you referred to Professional PT by: Surgeon Rehab MD Other: ____________

Have you had Surgery for this Injury? YES NO Number of Surgeries: 1 2 3 4 Other: _____

Type of Surgery: ____

Are You Currently Taking Any Prescription or Non-Prescription Medications: Yes No (Please List Below)

Anti-Inflammatories	Yes	No	______________________
Muscle Relaxers	Yes	No	______________________
Pain Medication	Yes	No	______________________
Other	Yes	No	______________________

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	___	___	General Practitioner	___	___
EMG/NCV	___	___	CT Scan	___	___
Massage Therapy	___	___	MRI	___	___
Milligram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Do you now or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	High Blood Pressure	___	___	Anemia	___	___
Shortness of Breath/Chest Pain	___	___	Heart Attack or Surgery	___	___	Diabetes	___	___
Coronary Heart Disease or Angina	___	___	Thyroid Trouble/Goiter	___	___	Gout	___	___
Cancer/chemotherapy/Radiation	___	___	Dizziness or Fainting	___	___	Weakness	___	___
Emotional/Psychological Problems	___	___	Infectious Diseases	___	___	Hernia	___	___
Bowel or Bladder Problems	___	___	Numbness or Tingling	___	___	Allergies	___	___
Severe or Frequent Headaches	___	___	Elbow/Hand Injury	___	___	Osteoporosis	___	___
Vision or Hearing Difficulties	___	___	Neck Injury/Surgery	___	___	Stroke/TIA	___	___
Sleeping Problems/Difficulties	___	___	Back Injury/Surgery	___	___	Blood Clot/Emboli	___	___
Leg/Ankle/Foot Injury/Surgery	___	___	Knee Injury/Surgery	___	___	Epilepsy/Seizures	___	___
Do you have a Pacemaker?	___	___	Arthritis/Swollen Joints	___	___	Varicose Veins	___	___
Any Pins or Metal Implants?	___	___	Are You Pregnant?	___	___	Joint Replacement	___	___
Weight Loss/Energy Loss	___	___	Do You Smoke?	___	___			

List any other information that would assist us in your care? ______________________________

____

Are you aware of what your diagnosis is (what you're being treated for)? Yes No

Based upon your awareness, what are your expectations/goals while in this program? ____________

____

Patient/Guardian Signature: ______________________ Date: ____________