



Background Information & Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with information regarding your health status found on this form. If you do not understand a question, leave the area blank and your therapist will assist you. Thank you!

Name: _____ Date: _____

Are you currently: (check one) Working at your usual no with no restrictions. Working at your usual job with restrictions. Unable to work because of your condition since: _____ Unable to work due to other medical reasons. Retired / Unemployed / Homemaker **Have you ever had physical therapy for this condition?** Circle: YES NO

Are you Seeing: Medical Doctor Dentist Psychiatrist/ Psychologist Osteopath Physical therapist Chiropractor

If you have seen any of the above during the last three months, please describe reason (illness, medical conditions, injury, routine physical, etc.)

Have you EVER been diagnosed as having any of the following conditions:

Yes No Heart problems Yes No Hearing loss/ disorder Yes No Circulation Problems
Yes No High blood pressure Yes No Eye Disease Yes No Osteoporosis
Yes No Stroke Yes No Muscle disease/disorder Yes No Cancer:
Yes No Rheumatoid Arthritis Yes No Multiple Sclerosis if yes, what kind: _____
Yes No Other Arthritic Problem Yes No Diabetes Yes No Past Pregnancy:
Yes No Epilepsy Yes No Tuberculosis Delivery (please circle): vaginal cesaria
Yes No Lung Disease Yes No Hepatitis Yes No Currently Pregnant? ___ months
Yes No Emphysema/ Bronchitis Yes No Kidney Disease Yes No Other: _____
Yes No Asthma Yes No Thyroid Problems
Yes No Chemical Dependency Yes No Depression

Please list any surgeries or other conditions for which you have been hospitalized, including dates and reasons.

Date	SURGERY	REASON:

Please describe any injuries for which you have been treated (fractures, dislocations, sprains/ strains).

Date	INJURY	Date	INJURY

Has anyone in you immediate family (parents, brothers, sisters) ever been treated for the following?

Yes No Diabetes Yes No Epilepsy Yes No Cancer
Yes No Heart disease Yes No Chemical dependency Yes No Headaches
Yes No Arthritis Yes No Tuberculosis Yes No Mental Illness
Yes No High blood pressure

Which of the following OVER-THE-COUNTER medications have you taken in the past week?

Yes No Aspirin Yes No Decongestants Yes No Antihistimines
Yes No Advil/ Motrin/ Ibuprofen Yes No Antacids Yes No Vitamins/ Mineral Supplements
Yes No Tylenol Yes No Laxatives Yes No Other: _____

List all PRESCRIPTION medicines you are currently taking (pills, injections, and skin patches):

Medicine Allergies: _____
How much caffeine per day? _____ **Cigarettes smoked per day?** _____ **Days a week you drink alcohol?** _____

Have you recently noted:

Yes No Weight loss/ gain Yes No Weakness Yes No Menstrual Irregularities
Yes No Nausea/ Vomiting Yes No Fever/ Chills/ Sweats Yes No Bladder Irregularities
Yes No Fatigue Yes No Numbness or tingling Yes No Rectal Bleeding

Form reviewed with patient: YES NO **Therapist signature:** _____ **Date:** _____