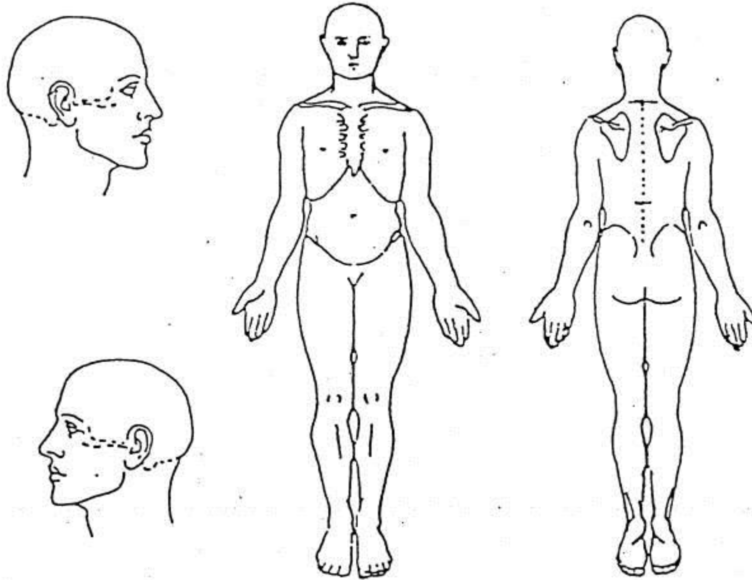
PRECISION PHYSICAL THERAPY **CONFIDENTIAL**

MEDICAL HISTORY FORM

Name ____ Date ______________

Birth date____________________ Email ____

Please mark the appropriate area of the diagram to show the location of your current symptoms:



Please describe your current symptoms:

Date of injury/surgery: _ _ / _ _ / _ _ _ _
(Month / day / year)

How did your symptoms begin?

Have you used any other forms of treatment for your current problem: (i.e. chiropractor, PT, acupuncture, etc.)?

Please List <u>All</u> Orthopedic or Abdominal Operations/Surgeries:

Operation Performed	Year
____	________________________
____	________________________
____	________________________
____	________________________

List the medications you are now taking:

List any special tests you have had for this condition: (X-rays, MRI, CT scan, etc.):

List any allergies you have to drugs, food or other items (including latex):

Pain Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms feel better? ____

What makes your symptoms feel worse? ____

What is your general overall health? Poor Fair Good Excellent

Stress Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Do you exercise? Yes No

- **If yes, what type of exercise?** ____
  - **How often?** ____

Have you had any of the following illnesses: (Please Circle)

High Blood Pressure	Multiple Chemical Sensitivity	Adrenal Fatigue
Diabetes (type I or II)	Candida (yeast allergy)	Restless Leg Syndrome
Thyroid Dysfunction	Eating Disorder	Pacemaker
High Cholesterol	Celiac Disease	Headaches, if yes, how often?
Heart Attack/Disease	Migraine Headaches	Osteoporosis
Asthma	Alcoholism	Osteopenia
Pulmonary Diseases	Anxiety	Chronic Pain
Stroke	Sleep Disorders	Fibromyalgia
Brain injury	Irritable Bowel Syndrome	Interstitial Cystitis
Blood clots	Ulcers	Chronic Pelvic Pain
Mental Illness/Depression	PTSD	Dysautonomia
Arthritis	Crohn’s Disease	Sensory Processing Disorder
Cancer	Elevated Heart Rate	Other serious illnesses: (Please Explain):

____ ______________________

Signature (parent/guardian signature if patient is a minor) **Date**