Nissenbaum and Schleusner PRO Physical Therapy LLC
Medical History Form

Name _____
Age_____ Height_____ Weight_____ Sex: Male/Female Handedness: Right/Left

Occupation_____

Work status: Full Time Part Time Not Working Medical Leave Retired Student

What are the problem(s) you are here for? _____

When did your symptoms/problems begin?_____

What started your symptoms? _____

Are your symptoms: Getting Better Worse Same Come and Go

Are your symptoms related to Work injury? Yes No Motor Vehicle Accident? Yes No
Sports Injury? Yes No Fall? Yes No
Overuse? Yes No

What symptoms are you experiencing with this complaint? (Circle all that apply)

Swelling Stiffness Numbness Tingling Fatigue Loss of balance Pain
Weakness Loss of Motion Other symptoms: _____

Are you currently off work because of this problem? Yes No Light duty

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Pain at LOWEST: Rate you lowest pain level in past 24 hrs.

_____

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable

Pain Currently: Rate your level of pain at this time.

_____

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable

Pain at WORST: Rate your highest pain level in past 24 hrs.

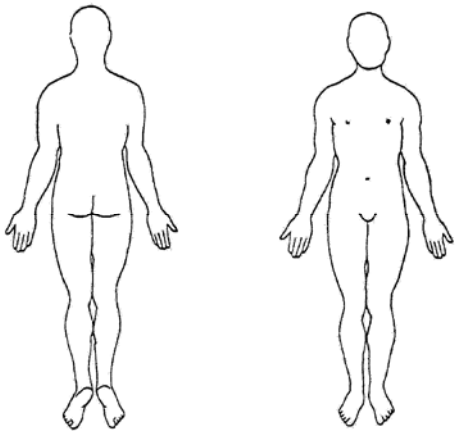
_____

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:
X sharp stabbing pain
O Dull achy pain
….Numb/Tingling
/// Throbbing
== Bur



What specific activities are you having difficulty with?

_____

What makes your symptoms <u>worse</u>? (please circle all that apply)
Sitting Standing Walking Lifting Bending Lying down Squatting Stress
Other_____

What makes your symptoms <u>better</u>? (please circle all that apply)
Sitting Standing Walking Lifting Bending Lying down Squatting Stress
Other_____

How do you sleep at night? No problem Toss and Turn Only with meds Fair

What time of day are your symptoms worst? _____ Best?_____

Have you had this problem before? Yes or No
If yes, when and how did it get better?_____

Any previous treatment for your current condition? Yes or No
Physical Therapy Chiropractic Injection Surgical intervention Alternative Medicine Acupuncture

What tests have you had for this complaint?
X-ray MRI CT Scan Diagnostic US Other _____

Any other orthopedic problems? Yes or No
If yes, please explain:_____

What is your general health? Excellent Good Fair Poor

Have you ever been diagnosed with or do you have any of the following conditions (check all that apply)

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ Osteoporosis
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Anxiety
- ☐ Depression
- ☐ Tuberculosis
- ☐ Sexually transmitted disease/ HIV
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Arthritis
- ☐ Bladder/urinary tract infection
- ☐ Kidney problems/infection
- ☐ Cholesterol high/low
- ☐ Epilepsy
- ☐ Thyroid problems
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Liver problems
- ☐ Diabetes
- ☐ Allergies/asthma
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ Chemical Dependency (Substance Abuse, Alcoholism)
- ☐ Recent Illness _____

Do you use tobacco? Yes No

Do you exercise regularly? Yes No

Any allergies? Yes No **Latex Allergy?** Yes No

Significant family medical history:_____
_____

Past surgical history? Yes No
If yes, please explain:_____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition (You can bring in a list in you would rather) _____
_____
_____

Does your current condition limit you in carrying out job duties? Yes No
Household duties? Yes No

Where do you currently live? House Apt/Condo Nursing Home

Do you live alone? Yes No

If you are over 65, how many falls have you had in the past 6 months? _____

What are your goals in physical therapy? _____
_____
_____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

Patient Signature _____ Date _____

FOR CLINIC USE ONLY

PT Initials _____ Date _____