Banner Physical Therapy
In partnership with Select Medical

Medical History Form

Patient Name: _____ Account Number: _____

Height: _____ft _____in Weight:_____(pounds) Date of injury:_____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? □ Yes □ No If Yes, date: _____

Have you had surgery for the present condition? □ Yes □ No If Yes, date: _____

If yes, surgery type:_____

Have you had any falls this past year? □Yes □No If Yes, how many?_____

Have you received previous treatment for this condition? □ Yes □ No If Yes, date: _____

If yes, please summarize:_____

Have you ever had any of the following? □ EMG □ CT SCAN □ MYELOGRAM □ MRI □ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	□ Yes	□No
Angina	□ Yes	□No
Anxiety or Panic Disorders	□ Yes	□No
Arthritis (RA, OA)	□ Yes	□No
Asthma	□ Yes	□No
Chronic Obstructive Pulmonary Disease (COPD)	□ Yes	□No
Congestive Heart Failure (CHF)	□ Yes	□No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	□ Yes	□No
Depression	□ Yes	□No
Diabetes	□ Yes	□No
Emphysema	□ Yes	□No
Hearing Impairment	□ Yes	□No
Heart Attack	□ Yes	□No
Multiple Sclerosis	□ Yes	□No
Osteoporosis	□ Yes	□No
Parkinson's Disease	□ Yes	□No
Peripheral Vascular disease	□ Yes	□No
Stroke or TIA	□ Yes	□No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	□ Yes	□No
Visual Impairment (cataracts, glaucoma, macular degeneration)	□ Yes	□No

Allergies	□ Yes	□No
Headaches	□ Yes	□No
Back Injury	□ Yes	□No
Bleeding Disorders	□ Yes	□No
Bowel / Bladder Abnormalities	□ Yes	□No
Cancer	□ Yes	□No
Dizzy or Fainting Spells	□ Yes	□No
Epilepsy or Seizure Disorder	□ Yes	□No
Fracture	□ Yes	□No
Hepatitis A, B, C	□ Yes	□No
Hernia	□ Yes	□No
High Blood Pressure	□ Yes	□No
HIV/AIDS	□ Yes	□No
Hypoglycemia	□ Yes	□No
Immunosuppressant Condition or Medication	□ Yes	□No
Kidney Problems	□ Yes	□No
Liver / Gallbladder Problems	□ Yes	□No
Metal Implants	□ Yes	□No
Nausea / Vomiting	□ Yes	□No
Pacemaker	□ Yes	□No
Defibrillator	□ Yes	□No
Pregnancy	□ Yes	□No
Ringing in Your Ears	□ Yes	□No
Sexual Dysfunction	□ Yes	□No
Skin Abnormalities	□ Yes	□No
Smoking	□ Yes	□No
Special Diet Guidelines	□ Yes	□No
Tuberculosis	□ Yes	□No

Please continue to 2nd page

Patient Name: _____ Account Number: _____

Are you on any medications? Click here if attached: □ Attached Please list (you may use reverse side):

_____

_____

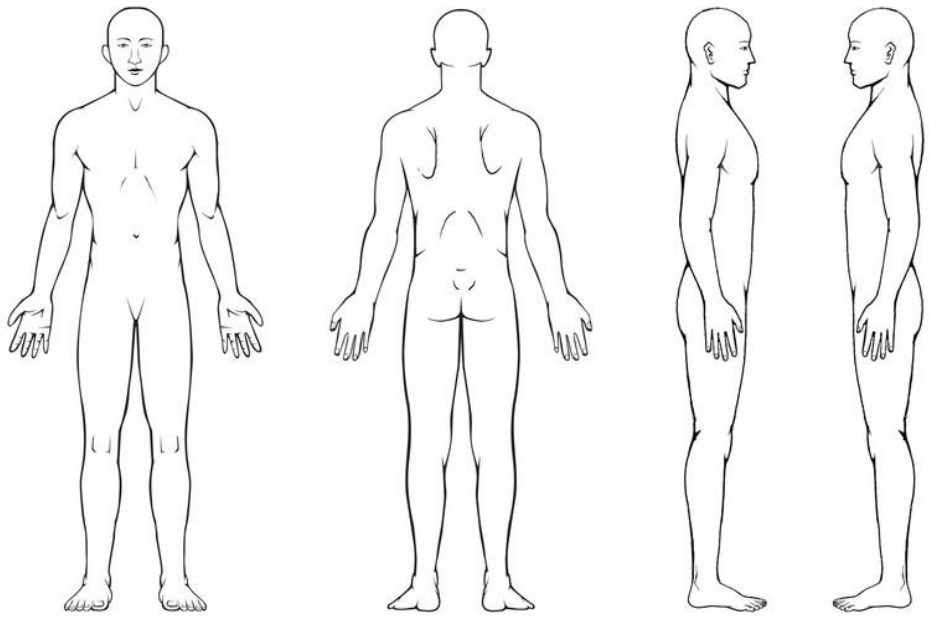
To help us understand your symptoms, please circle all that apply.

My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Is there any other information regarding your medical history that we should know about? _____

_____

What is your goal for therapy at this time? _____

_____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____