Magna Physical Therapy & Sports Medicine Center LLC

Medical History

Name: _____ **Date:** _____

Have you <u>RECENTLY</u> noted any of the following? (check all that apply)

- ☐ Headaches
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Weight loss/gain
- ☐ Difficulty with balance
- ☐ Shortness of breath
- ☐ Numbness/tingling
- ☐ Muscle weakness
- ☐ Dizziness/lightheaded
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Bowel/bladder changes
- ☐ Diarrhea or constipation
- ☐ Falls
- ☐ Fainting
- ☐ Cough
- ☐ Fatigue
- ☐ Infection

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bone/joint infection
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Cancer
- ☐ Cardiac/heart problems
- ☐ Arrhythmia
- ☐ Chest pain/angina
- ☐ Pacemaker or defibrillator
- ☐ Chemical dependency
- ☐ Circulation/vascular problems
- ☐ Blood or clotting disorders
- ☐ Raynaud's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy spells
- ☐ Emphysema/bronchitis
- ☐ Lung problems
- ☐ Pneumonia
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder problems
- ☐ Headaches
- ☐ Hearing impairment
- ☐ Hepatitis
- ☐ Liver problems
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Sexually transmitted infection
- ☐ Pelvic inflammatory disease
- ☐ HIV/AIDS
- ☐ Incontinence
- ☐ Kidney problems
- ☐ Urinary tract/bladder infection
- ☐ Metal implants
- ☐ MRSA
- ☐ Multiple sclerosis
- ☐ Muscular disease
- ☐ Osteopenia or osteoporosis
- ☐ Parkinson's
- ☐ Rheumatoid arthritis
- ☐ Seizures/epilepsy
- ☐ Smoking/tobacco use
- ☐ Speech problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Vision problems

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (check all that apply)

- ☐ Cancer
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ High blood pressure
- ☐ Depression
- ☐ Blood clots

During the past month have you been feeling down, depressed or hopeless? **Yes No**

During the past month have you been bothered by having little interest or pleasure in doing things? **Yes No**

Is this something with which you would like help? **Yes No**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **Yes No**

Have you received any of the following treatments in the past year?

Chiropractic	**Yes No**	Speech Therapy	**Yes No**
Home Care Physical Therapy	**Yes No**	Occupational Therapy	**Yes No**

Please list any allergies:

_____ Response: _____

_____ Response: _____

Please list any surgeries you have had:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please list any medications you are currently taking or attach a medication list:

Drug	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever taken steroid medication for any medical condition? **Yes No**

Have you ever taken blood thinners or anticoagulants for any medical condition? **Yes No**

Are you currently pregnant? **Yes No**

Do you currently exercise? **Yes No**

If yes, what types and how often? _____

Weight: _____lbs Height: _____ft_____in

Client/Patient/Guardian Signature:

_____ Date: _____

THE FOLLOWING ITEMS ARE SPECIFIC TO YOUR CURRENT INJURY/CONDITION

When did your current symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: **Getting Better** **Getting Worse** **Staying the Same**

I should avoid all physical activities that might make my pain worse:

Disagree **Agree** **Unsure**

Treatment received so far for this problem, with dates (chiropractic, injections, etc):

_____

Please list any tests performed for this problem, with dates (x-ray, MRI, labs, etc):

_____

Have you ever had this problem before? **Yes No** Did you have treatment? **Yes No**

How long did it take for you to feel better? _____

Are you currently able to sleep at night due to your symptoms?

No problem sleeping **Difficulty falling asleep**

Awakened by pain **Sleep with medication**

When are your symptoms worse? **Morning Afternoon Evening Night After exercise**

When are your symptoms better? **Morning Afternoon Evening Night After exercise**

How often do you experience your symptoms? **Constantly Frequently Occasionally**

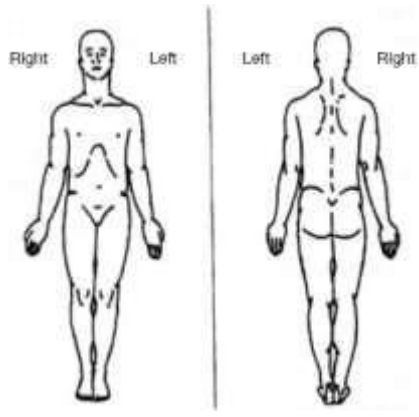
Using the 0 to 10 scale with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain right now: **_____/10**

The best your pain has been during the last 24 hours: **_____/10**

The worst your pain has been during the past 24 hours: **_____/10**

Please indicate on the diagram to the right where you feel your pain. →



Client/Patient/Guardian Signature:

_____ Date: _____