InMotion
PHYSICAL THERAPY & FITNESS

Patient Medical History

Name:_____ Referring Physician:_____

Check if you now have or have you ever had ANY of the following?
Circle if more than one choice is appropriate.

_____ *Asthma, Bronchitis, or Emphysema*
_____ *Shortness of Breath/Chest pain*
_____ *Coronary Heart Disease*
_____ *Do you have a Pacemaker*
_____ *High Blood Pressure*
_____ *Heart Attack or Surgery*
_____ *Stroke/TIA*
_____ *Congestive Heart Disease/Failure*
_____ *Blood Clot/Emboli*
_____ *Epilepsy/Seizures*
_____ *Thyroid Disease or Goiter*
_____ *Anemia*
_____ *Infectious Diseases*
_____ *Diabetes Type I or Type II*
_____ *Cancer or Chemotherapy/Radiation*
_____ *Osteoarthritis or Rheumatoid Arthritis*
_____ *Osteoporosis or Osteopenia*
_____ *Gout*
_____ *Sleeping Problems/Difficulties*
_____ *Depression or Anxiety*

_____ *Severe or Frequent Headaches*
_____ *Vision or Hearing Difficulties*
_____ *Numbness or Tingling*
_____ *Dizziness/Fainting/Imbalance*
_____ *Weakness*
_____ *Weight Loss/Energy Loss*
_____ *Bowel or Bladder Problems*
_____ *Hernia*
_____ *Vericose Veins*
_____ *Pins or Metal Implants*
_____ *Joint Replacement Surgery*
_____ *Neck Injury/Surgery*
_____ *Shoulder Injury/Surgery*
_____ *Elbow Injury/Surgery*
_____ *Back Injury/Surgery*
_____ *Knee Injury/Surgery*
_____ *Leg/Ankle/Foot Injury/Surgery*
Are You Pregnant? *YES/ NO*
Do You Use Tobacco? *YES/ NO*

Is this a work injury? Yes/No ***Last date worked due to injury:_____***

Please provide some detail if this is a work related injury:

_____

Please circle if you have had any of the following tests: MRI, EMG, CAT scan, X-ray

Have you had surgery for this injury? Yes/No ***Date:_____***

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List or provide a list of current prescription medications:

_____

_____

Are you allergic to any medications? Please list_____

List any other information that would assist us in your care:

_____

_____

Please tell us about your current pain. (0-10) 0=No pain/10=excruciating pain

What is your current pain level? (0-10) _____

Is your pain constant/intermittent?_____

Has your pain been improving, worsening, or not changing?_____

What improves your pain level?_____

What makes your pain level worse?_____

After your discharge from Physical Therapy, what activities do you want to participate in that you currently cannot or have difficulty doing secondary to your pain/dysfunction?

_____

_____

Patient/Guardian Signature: _____ Date: _____