Medical History Form

Welcome to Sawtooth Physical Therapy. Please take a moment to fill out your medical history as accurately and completely as possible. This information helps us to deliver the most comprehensive care to you. Your physical therapist will review this information with you during your first appointment.

Name: _____ Date of Birth: _____

CURRENT INJURY CONDITION:

Why are you coming here today (describe injury or condition)? _____

_____

When did your condition Begin? _____ Work Related: ☐ Yes ☐ No Next MD appointment *(date):* _____

Surgery Date *(if applicable)*: _____ Type of Surgery: _____

CURRENT SYMPTOMS:

Rate symptom intensity in the past 5 days (0 is no pain or symptoms, 10 is the worst imaginable pain or symptoms):

Symptoms at worst: _____ Symptoms at Best: _____

Have you received other therapies in the past 12 months? ☐ Yes ☐ No

MEDICAL CONDITIONS: (Do you have a history of?)

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Abnormal Bleeding	☐	☐	Degenerative Joint	☐	☐	Joint Pain
☐	☐	Angina	☐	☐	Depression	☐	☐	Lymphedema
☐	☐	Anxiety	☐	☐	Diabetes (Type 1)	☐	☐	Migraine Headaches
☐	☐	Arrhythmia	☐	☐	Diabetes (Type 2)	☐	☐	MRSA
☐	☐	Asthma	☐	☐	DVT	☐	☐	Multiple Sclerosis
☐	☐	Bipolar Disorder	☐	☐	Fibromyalgia	☐	☐	MI/Heart Attack
☐	☐	Blood Clotting Disorder	☐	☐	Frequent UTI	☐	☐	Osteoarthritis
☐	☐	Bowel Incontinence	☐	☐	GERD	☐	☐	Osteoporosis
☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Psoriatic Arthritis
☐	☐	Carpal Tunnel Syndrome	☐	☐	Gout	☐	☐	PVD
☐	☐	Cellulitis	☐	☐	Heart Disease	☐	☐	Rheumatoid Arthritis
☐	☐	Chronic Back Pain	☐	☐	Hep B	☐	☐	Scoliosis
☐	☐	Chronic Neck Pain	☐	☐	Hep C	☐	☐	Seizure Disorder
☐	☐	Crohn's Disease	☐	☐	Hiatal Hernia	☐	☐	Shortness of Breath
☐	☐	Closed Head Injury	☐	☐	High Cholesterol	☐	☐	Sleeping Disorder
☐	☐	Colitis	☐	☐	HIV/AIDS	☐	☐	TB
☐	☐	Congestive Heart Failure	☐	☐	Hypertension	☐	☐	Urinary Incontinence
☐	☐	COPD	☐	☐	Hypothyroidism	☐	☐	Other: _____
☐	☐	CVA (Stroke)	☐	☐	Irritable Bowel Syndrome	☐	☐	Other: _____

Do you have a pacemaker? ☐ Yes ☐ No Are you currently pregnant? ☐ Yes ☐ No

MEDICATIONS:

Please list all prescription and over-the-counter: *(attach separate sheet if necessary):* _____

_____

_____

VITAMINS & SUPPLEMENTS:

Please list all vitamins & supplements: _____

_____

ALLERGIES:

Please list any known allergies: _____

SURGICAL HISTORY:

Please list all past surgeries with dates: _____

_____

DIAGNOSTIC TESTS:

Have you had any X-rays? MRI? CT Scan? Ultrasound? Other? related to this condition *(Please List):*

_____

_____

SOCIAL HISTORY:

Do you currently smoke? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never Packs/Day: _____

Have you smoked in the past? ☐ Yes ☐ No How many years did you smoke for? _____ Packs/Day: _____

How many years ago did you quit smoking? _____

Do you drink alcohol? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never Drinks/week: _____

Hobbies / Activities? _____

FUNCTIONAL STATUS:

Occupation: _____ Work Status: _____ Restrictions: _____

Normal Work Duties:	Yes	No (*able to perform)*		Yes	No
Sitting for extended periods of time	☐	☐	Lifting Heavy Weights	☐	☐
Standing for extended periods of time	☐	☐	Operating Heavy Equipment	☐	☐
Repetitive Bending	☐	☐	Driving	☐	☐
Repetitive Lifting	☐	☐	Typing / Computer Operation	☐	☐
Lifting moderate Weights	☐	☐	Walking	☐	☐

Have you fallen in the last 12 months? ☐ Yes ☐ No How Many falls? _____

If patient is a minor: Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Patient (Guardian) Signature: _____ Date: _____