South Florida Rehab & Training Center

MEDICAL HISTORY FORM

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures and for their effectiveness and your safety. Fees will vary according to your treatment/condition. Thank you.

Patient_____

Area of Symptoms:_____ Date of Onset: _____Age:_____

Describe your symptoms: _____

How did your symptoms start:_____

How often do you experience symptoms?

Never / Rarely / Occasionally / Frequently / Constantly

In general, would you say your overall health right now is:

Excellent / Very Good / Good / Fair / Poor

Any known results of recent radiographs, MRI, CT, PET or other tests?_____

Have you had Physical Therapy in the past? No ☐ Yes ☐ If so, why?:_____

Past Injuries:_____

Chronic Conditions: No ☐ Yes ☐ Please list:_____

Allergies: No ☐ Yes ☐ Please list:_____

List surgeries and dates:_____

Current Medications: _____

Personal Medical History: Check all that apply

Cancer	No ☐ Yes ☐	High Blood Pressure	No ☐ Yes ☐
Diabetes	No ☐ Yes ☐	Metal Implants	No ☐ Yes ☐
Epilepsy or Seizures	No ☐ Yes ☐	Respiratory Problems	No ☐ Yes ☐
Heart Disease	No ☐ Yes ☐	Osteoporosis	No ☐ Yes ☐
Blood Disorders	No ☐ Yes ☐	Are you pregnant?	No ☐ Yes ☐
HIV/AIDS	No ☐ Yes ☐	Smoker	No ☐ Yes ☐

1. How would you rate your ability to perform routine daily activities?
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% No Problems Unable to perform

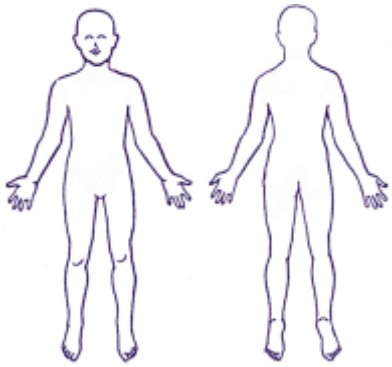
2. How would you rate your ability to perform the activities associated with your job?
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% No Problems Unable to perform

3. How would you rate your current pain? None 0 1 2 3 4 5 6 7 8 9 10 Emergency Room

4. How many days since your current injuries? 0-30days ☐ 31-90 days ☐ 90+ days ☐

Please draw your pain on the body to the right using the following symbols:

///	Stabbing Pain
xxx	Burning
ooo	Pins and Needles
= = =	Numbness



_____**Your treatment only covers one body part**
(Initials)

Patient/Guardian Signature:_____ **Date** _____