

# Medical History

Name: \_\_\_\_\_

D/O/B: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician: \_\_\_\_\_  
 Amount of weekly exercise: Never 1x 2x 3x 4x (or more)  
 Do you live alone? YES NO  
 Do you use a wheelchair? YES NO  
 Do you use a walker? YES NO

Date of Injury/Onset (if applicable): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Do you use a cane? YES NO  
 Are you a caregiver for someone else? YES NO  
 Does your home have stairs? YES NO

How many times have you fallen within the last year? \_\_\_\_\_  
 If you have fallen, were you injured? YES NO

Have you had surgery for this injury? YES NO  
 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery: \_\_\_\_\_

<b>Does your diagnosis impact your ability to work?</b>	<b>Does your diagnosis impact your ability to attend school?</b>	<b>Does your daily routine/activities aggravate your diagnosis?</b>
Retired _____	Prevents me from attending _____	No _____
Prevents me from working _____	Big impact _____	Unable to participate _____
Can only work part time _____	Minor impact _____	Aggravates injury 1x week _____
Can work with great difficulty _____	School is normal, but no sports _____	Aggravates injury 2x week _____
Can work with minor difficulty _____	No impact _____	Aggravates injury 3x (or more) week _____
No impact _____	Not applicable _____	Aggravates injury every day _____
Not applicable _____		

**Describe your pain/symptoms?** (circle all that apply):  
 Aching / Burning / Constant / Cramping / Deep / Dull / Heavy / Numb / Pins and Needles / Stabbing / Throbbing / Variable / Weak

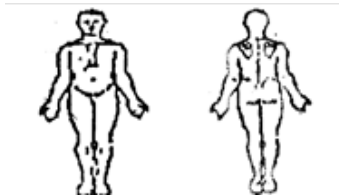
**What makes your pain/symptoms worse?** (circle all that apply):  
 Reaching back / Lying flat / Getting up out of bed / Dressing or grooming / Cooking / Carrying items / Climbing stairs / Lifting anything / Lifting heavy weights / Pulling / Twisting / Raising arm over head / Looking up or down / Walking

**What relieves your pain/symptoms?** (circle all that apply):  
 Ice / Heat / Stretching / Exercise / Pain medication / Lying flat / Avoiding activity / Nothing

Please list all medications, with dosage, that you are currently taking: \_\_\_\_\_

**INDICATE ON THE DIAGRAM WHERE THE PAIN IS**

**PAIN SCALE – PLEASE INDICATE YOUR PAIN LEVEL**



**Initial Occurrence:** (no pain) 1 2 3 4 5 6 7 8 9 10 (extreme)  
**At WORST:** (no pain) 1 2 3 4 5 6 7 8 9 10 (extreme)  
**At BEST:** (no pain) 1 2 3 4 5 6 7 8 9 10 (extreme)

**CIRCLE EACH OF THE TOPICS THAT RELATE TO YOUR MEDICAL HISTORY**

- |                                |                              |                             |
|--------------------------------|------------------------------|-----------------------------|
| Allergies                      | Epilepsy/Seizures            | Thyroid Problem             |
| Anemia                         | Gout                         | Varicose Veins              |
| Angina                         | Hearing Difficulties         | Vertigo/Balance             |
| Asthma                         | Heart Attack                 | Vision Difficulties         |
| Back Pain                      | Hernia                       | Weakness                    |
| Blood Clot/Emboli              | High Blood Pressure          | Weight Loss                 |
| Bowel/Bladder Problems         | Incontinence                 | Women's Health Issue(s)     |
| Bronchitis                     | Infectious Disease           | Ankle Injury LEFT/RIGHT     |
| Cancer                         | Kidney Disease               | Elbow Injury LEFT/RIGHT     |
| Complex Regional Pain Syndrome | Other Important Issues _____ | Hip Injury LEFT/RIGHT       |
| Coronary Heart Disease         | Pacemaker                    | Knee Injury LEFT/RIGHT      |
| Currently Pregnant             | Parkinson's                  | Leg Injury LEFT/RIGHT       |
| Diabetes, type 1               | Pelvic Floor                 | Shoulder Injury LEFT/RIGHT  |
| Diabetes, type 2               | Pneumonia                    | Wrist Injury LEFT/RIGHT     |
| Dizziness/Faintness            | Severe/Frequent Headaches    | Arthritis _____             |
| Drink Alcohol                  | Sleeping Problems            | Joint Replacement _____     |
| Emphysema                      | Smoke Cigarettes             | Numbness/Tingling _____     |
| Energy Loss                    | Stroke/TA                    | Pins or Metal Implant _____ |

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Darien Physical Therapy Center regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collections costs that are incurred.

**Patient/Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.  
**Patient/Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_