Revitalize PHYSICAL THERAPY

Medical History Form

Name: _____ Date: _____

Date of birth: _____ Occupation: _____

Street address: _____

City, State, Zip: _____

Home phone: _____ Mobile phone: _____

Email address: _____

Physician: _____ Phone Number: _____

Other Healthcare Provider (OBGYN, Chiropractor, etc): _____

How did you hear about us? _____

Emergency contact name: _____

Relationship: _____ Phone: _____

History of current condition: _____

_____

_____

_____

Is there anything that makes it better? _____

Is there anything that makes it worse? _____

Any special tests that have been performed and results of them (X-Ray, MRI, Cat Scan, etc):

_____

Have you had surgery related to this injury? ☐ YES ☐ NO

If yes, what type of surgery? _____ Date of surgery: _____

Have you had any other treatment for your current condition (Chiropractor, Massage, Acupuncture, etc)?

_____

Are you currently receiving Physical Therapy elsewhere? ☐ YES ☐ NO

Patient/Guardian Signature: _____ Date: _____

Revitalize PHYSICAL THERAPY

Medical History Form - Continued

Please list all past surgeries, injuries, accidents or other pertinent medical history:

_____

_____

Please list all current medications:

_____

Do you currently participate in sports or exercise programs on a regular basis?

_____

PLEASE CHECK IF YOU HAVE OR HAVE EVER EXPERIENCED THE FOLLOWING:

☐ Diabetes	☐ Seizures	☐ Sexual Dysfunction
☐ Chest Pain	☐ Headaches	☐ Incontinence
☐ High Blood Pressure	☐ Dizziness/Vertigo	☐ Organ Prolapse
☐ Heart Attack	☐ Concussion	☐ Hernia
☐ Pacemaker	☐ Ringing in Your Ears	☐ MRSA
☐ Heart or Vascular Disease	☐ Jaw Clicking/Locking	☐ HIV
☐ CVA/Stroke/TIA	☐ Blood Clots	☐ Hepatitis
☐ COPD	☐ Depression	☐ Cancer _____
☐ Asthma	☐ Anxiety	☐ Allergies _____

FOR WOMEN ONLY:

Please list number of: _____ Pregnancies _____ Children Ages:_____

Date of last pelvic exam: _____

Date of last pap smear test: _____ ☐ Positive ☐ Negative

Please check all that apply:

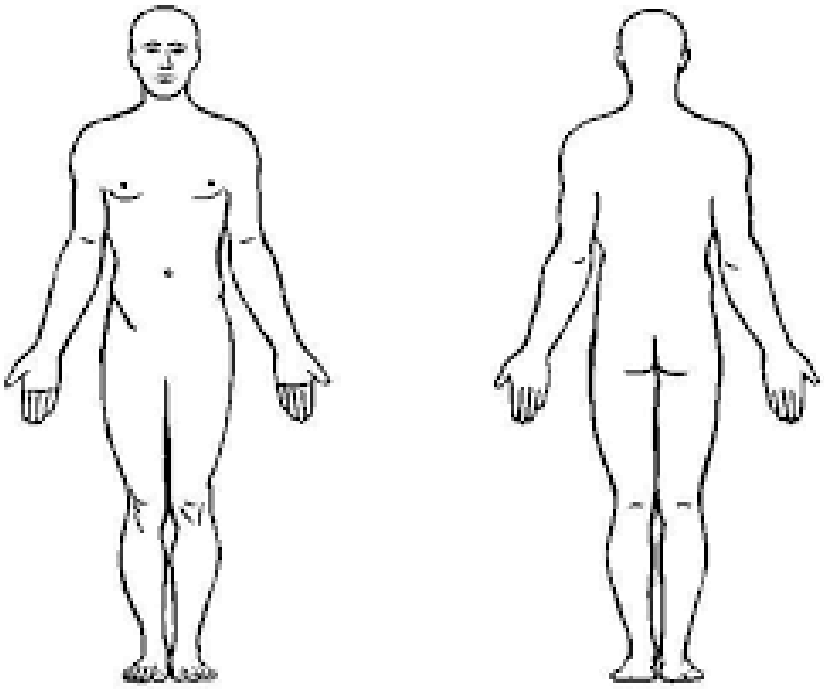
☐ Irregular menstrual cycle	☐ Pain with intercourse
☐ Pain and cramping during period	☐ Pelvic pressure/heaviness
☐ History of Cesarean section	☐ Bladder urgency/frequency

Patient/Guardian Signature: _____ Date: _____

Revitalize PHYSICAL THERAPY

Medical History Form - Continued

Please indicate where your symptoms are located:



Please circle the appropriate number that best describes your pain level:

0	No pain
1	Mild pain, you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication
4-5	More severe pain, you begin to reduce your activity level
6	Severe Pain
7-9	Intensely Severe Pain
10	Most Severe Pain, may require a visit to Emergency Room

Patient/Guardian Signature: _____ Date: _____