PREP
PHYSICAL THERAPY

New Patient Medical History

Name: ______________________ What brings you to therapy? ______________________

Referring Physician: ______________ Next visit with Dr: _________ Currently receiving disability? _________

Is your condition due to: Auto-accident: ___ Fall: ___ Work injury: ___ Other:_________ Date of onset: _________

What is your goal for therapy? ____

Please rate your pain using a number 1-10 below:

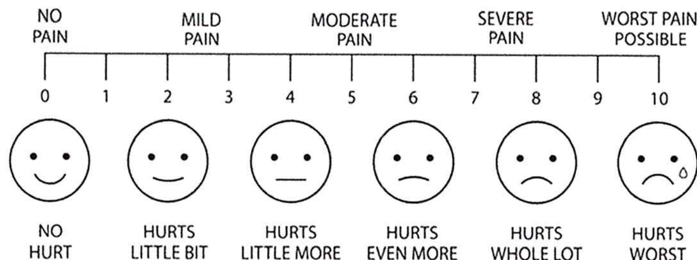
Pain at time of injury: _______ Pain at present time : _______

What makes pain worse: ______________________________

____

What makes pain better: ______________________________

____



Do you currently have, or have had any of the following conditions?

Asthma ____ Dizziness ____ Tuberculosis (TB) ____ Pacemaker ____

Arthritis ____ Diabetes ____ Heart Disease ____ Osteoporosis ____

Cancer ____ Respiratory (COPD) ____ Stomach/Gastrointestinal ____

Stroke ____ Joint Replacement ____ Circulation/Vascular ____

Heart Attack ____ Kidney/Urinary ____ Pregnancy (currently) ____

Epilepsy/Seizures ____ Skin Problems ____ Intestinal Trauma ____

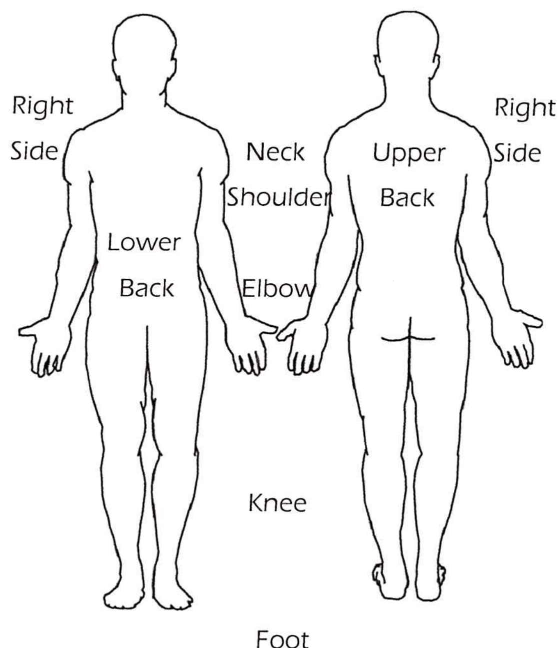
Psychiatric History ____ Cough ____ Sleeping ____ Fatigue ____

Bowel Control ____ Bladder Control ____ Blurry/Double vision ____

Shortness of Breath ____ Depression ____ Nausea/Vomiting ____

Swelling/Edema ____ Weight Loss or Gain ____ Chest pain ____

Other ____



Please list any current medications you are taking. You may also provide us with a list of medications to keep in your records.

Drug/Dosage: ____

____

Please list any known allergies: ____

Please list any prior surgeries/ hospitalizations and dates: ______________________________

____

Patient/Guardian Signature: ______________________________ Date: ______________