DYNAMIC SPORTS PHYSCIAL THERAPY

MEDICAL HISTORY FORM

Patient Name:_____ Date: _____/_____/_____

Date of next physician's visit: _____/_____/_____

Date of injury/onset : _____/_____/_____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your current condition:

☐ traumatic
☐ repetitive
☐ work-related
☐ motor vehicle accident
☐ recurrence of previous injury
☐ athletic injury
☐ unknown

Have you had a related surgery? ☐ Yes ☐ No

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

☐ Diabetes
☐ Chest Pain/Angina
☐ High Blood Pressure
☐ Heart Disease
☐ Heart Attack
☐ Heart Palpitations
☐ Pacemaker
☐ Headaches
☐ Kidney Problems
☐ Are you pregnant?
☐ Cancer
☐ Osteoporosis
☐ Bowel / Bladder Abnormalities
☐ Urine Leakage
☐ Asthma / Breathing Difficulties
☐ Liver / Gallbladder Problems
☐ Smoking
☐ Double vision
☐ Allergies to Aspirin
☐ Allergies to Heat / Cold
☐ Allergies
☐ Hernia
☐ Seizures
☐ Metal Implants
☐ Dizziness / Fainting
☐ Recent Fractures
☐ Surgeries
☐ Skin Abnormalities
☐ Sexual Dysfunction
☐ Nausea / Vomiting
☐ Ringing in your ears
☐ Rheumatoid Arthritis
☐ Special Diet Guidelines
☐ Hypoglycemia
☐ Stroke / CVA
☐ Slurred speech
☐ Difficulty swallowing
☐ Unexplained weight loss
☐ Bowel / Bladder changes
☐ Groin / Pelvic Numbness
☐ Other

If yes to any of the above, please briefly explain and give approximate dates:

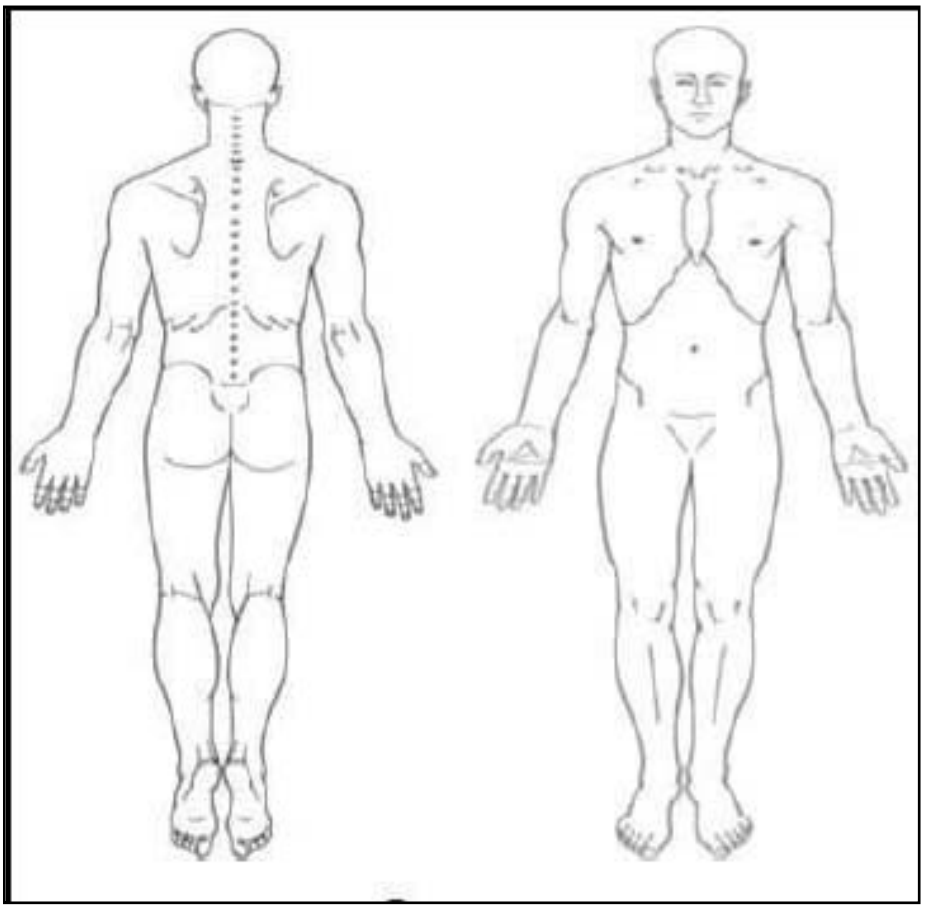
Is there any other information regarding your past medical history that we should know about?

Are you presently taking medication? ☐ Yes ☐ No
If yes, please list what medications and for what condition:

Medication & Condition	Dosage	Frequency

Have you had any recent diagnostic tests (i.e. x-rays, MRIs), please include approximate date of the test.

Indicate where you have pain or other symptoms:



KEY:

Numbness =========

Pins & Needles ooooooooo

Burning Pain xxxxxxxxxxxxx

Stabbing Pain //////////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible._____

_____ _____ Date:_____

Patient's Signature Signature of Guardian (if patient is a minor)

_____ Date:_____

Therapist Signature

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