All Star Physical Therapy, Inc.
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Brief Medical History

Patient Name: _____ Height: _____ Weight:_____ Age:_____Gender: M / F

How did you hurt yourself (MOI): _____

Diagnosis:_____Date of Injury (DOI): _____ Date of Surgery (DOS): _____

X-ray/MRI/special test Results: _____

Any past conditions/injury/surgery related to your current pain (PMH): Y / N Explain:_____

Are you working: Y / N What is your job title:_____# of years working: _____

What positions, movements, activities are difficult (circle): sitting / standing / bending / twisting kneeling / squatting /sit-to-stand walking / up/down stairs / reaching / gripping / grasping / lifting / carrying / other: _____
What does it feel like (circle): burning / sharp / dull / achy / throbbing / shooting / numbness / tingling / constant / intermittent

How intense is your pain at worst (circle): no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain
How intense is your pain currently (circle): no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain
How intense is your pain at best (circle): no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain

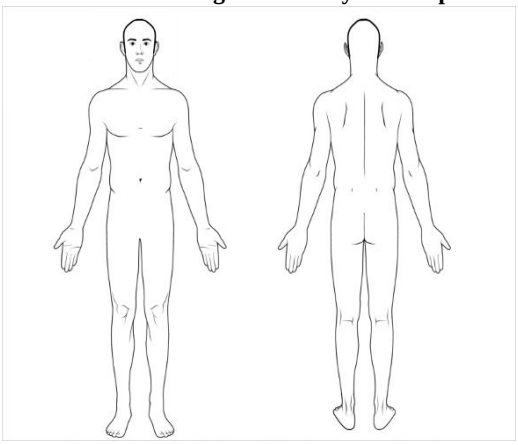
Fall History: Injury as a result of a fall in the past year? Y / N Two or more falls in the last year? Y / N

List of Medications

I do not take any medications ☐

What I take, and how much?	Why I take it?	When I take it?	How do I take it? (oral,topical)

Mark on the diagram where you have pain.



Do you now or have you ever had any of the following?

Alzheimer's	Yes No	History of Cancer	Yes No
Cardiovascular Disease	Yes No	Huntington's	Yes No
Cauda Equina Disease	Yes No	Immunosuppression	Yes No
Cerebral Vascular Accident	Yes No	Lupus	Yes No
Current Infection	Yes No	Muscular Dystrophy	Yes No
Diabetes Mellitus Type 1	Yes No	Obesity	Yes No
Diabetes Mellitus Type 2	Yes No	Osteoarthritis	Yes No
Fibromyalgia	Yes No	Parkinson's	Yes No
Fracture	Yes No	Rheumatoid Arthritis	Yes No
Suspected Fracture	Yes No	Traumatic Brain Injury	Yes No
High Blood Pressure	Yes No	Pacemaker	Yes No
MRSA	Yes No	HIV	Yes No

Other (please list below):

_____
_____
_____

If changes occur at any time during treatment, please notify your therapist.

_____ _____
Signature Date

Revised 12/16