

New Mexico Sports Fitness & Physical Therapy, Inc.

Patient Medical History

Name: _____ Age _____ Date ____/____/____

Chief Complaint

1. Reason for seeing Physical Therapy or Occupational Therapy today? _____

History of Present Illness

2. When did your problem, pain or injury begin? _____

3. How did your problem start? Suddenly____ Slowly over time____ During Sports____ At work____
(Please check all that apply) Fall____ Lifting____ Pulling____ Auto Accident____ No cause____

4. What are your symptoms? Pain____ Swelling____ Redness____ Bruising____ Spasm____
(Please check all that apply) Weakness____ Tingling____ Locking____ Catching____ Give way____

5. If you have pain, describe it. Constant____ Intermittent____ While at rest____ At night____
(Please check all that apply) With activity____ Burning____ Aching____ Sharp____ Dull____

6. On average, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

7. What reduces your symptoms? Sitting____ Lying down____ Stopping activities____ Standing____
(Please check all that apply) Walking____ Medication____ Physical Therapy____ Ice____ Heat____

8. What makes your problem worse? Sitting____ Standing____ Walking____ Bending____ Cough/Sneeze____
(Please check all that apply) Exercise (during)____ Exercise(after)____ Other_____

9. Have you had any diagnostic tests for this problem? X-Rays____ CT scan____ MRI____ Injections____
Arthrogram (dye injection)____ Electromyogram/ nerve condition study____
Dates: ____/____/____ Place: _____ Do you have them:

10. Were you seen in the emergency room for this problem? Yes____ No____ Date: ____/____/____

Review of Systems

11. Have you, the patient, ever been diagnosed with any of the following conditions? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Vision or hearing problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Asthma or emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Stomach problems/ulcers/reflux | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Bowel or bladder problems | <input type="checkbox"/> Contagious conditions |
| <input type="checkbox"/> Kidney disease/ failure | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> TB |
| <input type="checkbox"/> Bone or joint problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> None of the above |

Past Medical History

12. Please list **ALL** previous surgeries, hospitalizations and /or broken bones.

- a. _____ date ___/___/___ d. _____ date ___/___/___
- b. _____ date ___/___/___ e. _____ date ___/___/___
- c. _____ date ___/___/___ f. _____ date ___/___/___

13. Please list **ALL** your current medications and their doses. Include “over-the-counter” meds and herbals.

- | Medication | Dose | Medication | Dose |
|------------|-------|------------|-------|
| a. _____ | _____ | d. _____ | _____ |
| b. _____ | _____ | e. _____ | _____ |
| c. _____ | _____ | f. _____ | _____ |

14. Are you allergic to any medications? YES____ NO____ Please list:_____

15. Women only: Are you, or could you be, pregnant? YES____ NO____ Due date: ___/___/___

Family History

16. Does any blood relative have a history of any of the following medical problems? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Rheumatoid arthritis/Osteoarthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Problems with anesthesia |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Other (please list) _____ | |

Social History

17. What is your occupation? _____

Employer _____

18. What are your work and active daily living requirements? _____

19. Do/did you use tobacco? YES____ NO____ How much? _____ Quit when? _____

20. Do you drink alcoholic beverages? YES____ NO____ How many drinks per day? _____

21. Have you ever been addicted to prescription or non-prescription drugs? YES____ NO____ Which? _____

22. Do you live alone? YES____ NO____

23. How often do you exercise? Never____ Rarely____ Monthly____ Weekly____ Daily____

What type of exercise? _____

24. Which is your dominant hand? RIGHT____ LEFT____ BOTH____

Miscellaneous

25. Were you referred here by a physician? YES____ NO____ Name _____

26. Who is your primary care physician? Name _____

27. Is there any legal action pending that pertains to your visit? YES____ NO____

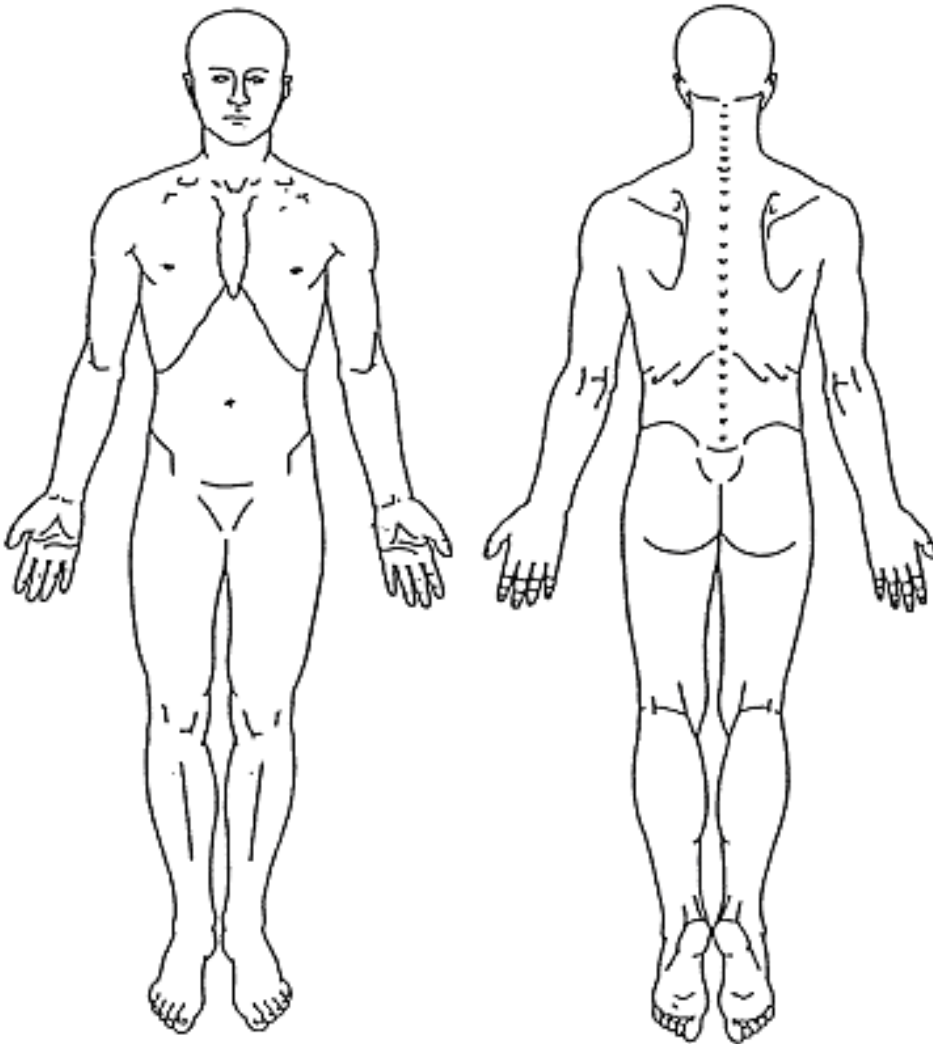
Describe _____

What would you like to accomplish with Physical Therapy \ Occupational Therapy?

- Return to hobby/recreation /sport
- Return to work
- Improve strength and motion
- Decrease pain
- Improve daily function
- Other: _____

What is the date that you return to the doctor? ____/____/____

Please shade the area(s) below where your symptoms are located:



**If you have pain, please write the intensity between 0-10 next to the shaded area.
(0=No Pain, 5=Moderate Pain, 10=Severe Pain)**

Signature of patient or parent of minor

____/____/____
Date

To all patients:

In order for our facility to be Medicare certified it is required that we have every patient fill out this form. If for some reason you feel this form does not pertain to you, please note it where indicated below. We are also required to have you sign and date this form. THANK YOU.

You may request an appointment with our medical Social Worker at the front desk.

(If you are not interested in seeing a medical social worker for counseling, please sign and date the following line)

I am NOT interested: _____
Signature of patient Date

(If you are interested in seeing a Medical Social Worker for counseling, please sign, date and complete the rest of this form.)

Patient Name: _____ Age: _____

Marital Status: Single Married Widowed Divorced Separated

- 1. If necessary, is there someone who can assist you with household and daily tasks? Yes No
- 2. Are you presently working? Yes No
- 3. Is there a lawsuit pending? Yes No
- 4. Do you feel depressed and/or anxious about your injury? Yes No
If yes, have you or are you currently receiving counseling? Yes No

Patient' Signature: _____ Date: _____

Physical Therapist: _____ Date: _____

Social Worker: _____ Date: _____