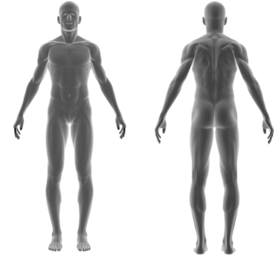
Medical History

Name _______________________________________ Date ____________________

Describe Injury/Surgery: ____

Date of Injury/Surgery: ____



Check any and all that apply to your present health.

Heart Attack	Pace Maker	Arrythmias	
Incontinence	Night Pain	Metal Implants	
Headaches	Chronic Pain	Allergies	
Heart Disease	Vision Problems	Shortness of Breath	Blood Clots
Stroke	Allergic to Latex	Numbness/Tingling	Pregnancy
High/Low Blood Pressure	Weakness	Diabetes	Hearing Loss
Swelling	Fatigue	Prostate Problems	Cancer/Tumors
Nausea	Seizure	Blood in Stool/Urine	Rheumatoid Arthritis
Infectious Disease	Depression	Thyroid Problems	Dizziness

Previous Surgeries: ____

Other Medical Conditions: ____

X-Ray, MRI Results for this Injury: ____

List all Prescribed Medications: ____

List Previous Major Injuries/Surgeries: ____

Rate your current level of pain from 0-10 (0 is no pain at all and 10 is the worst pain imaginable): _________

Level of Pain at its Worst (0-10): _________ Level of Pain at its Best (0-10): _________

Describe your pain. Check all that apply.

Aching	Burning	Tingling	Numbness
Sharp	Dull	Throbbing	Cramping

Does your pain radiate down your arms or legs? _________

What seems to help the most? ____

What seems to aggravate the condition the most? Check all that apply.

Sitting	Standing	Walking	Climbing Stairs
Laying Down	Lifting	Reaching	Other ____________________

Can you drive a car? _________ Can you climb stairs? _________

What is your main activity at work?	On the Phone	Sitting	Computer work
	Physical Labor	Driving a Car	Walking

What Personal goal would you like to achieve from therapy?

____

31461 Rancho Viejo Rd., Suite 101, San Juan Capistrano, CA, 92675
TEL (949) 542-5000 FAX (949) 940-8449 * www.freemotionpt.com