Preferred
Physical Therapy
Our mission is to heal. Our passion is to care

Medical History Form

Name: _____ Age:_____ Today's Date: _____

Occupation/Sport:_____ Onset/Injury Date:_____ Surgery Date: _____

Referring Physician:_____ Next Doctors Appt: _____

Is this: ☐ Work related? ☐ Auto Related? ☐ N/A

Describe your current condition and how it began:

Have you had any tests for this condition? ☐ X-ray ☐ MRI ☐ Injections ☐ CT scan ☐ N/A

If yes, date:_____

Have you received treatment for your condition before today? If yes, from whom?

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other:_____

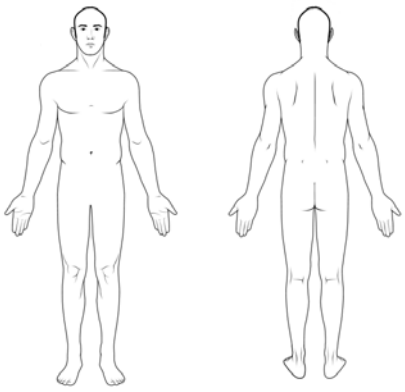
What treatments did you receive and when? _____

How is your condition changing? ☐ Getting better ☐ No change ☐ Getting Worse

In the past week, how much has your pain interfered with your daily activities? (ie: Household chores, work, social activities, etc.)

No Interference | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **Unable**

Please shade the areas of pain:



Pain: Where? _____

What makes the pain worse? _____

What makes the pain better? _____

Numbness: ☐ NO ☐ YES, where: _____

What increases numbness?_____

What decreases numbness? _____

Swelling: ☐ NO ☐ YES, where: _____

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ADDRESS 18301 N. 79th Ave. B122 Glendale, Arizona 85308

Rate your pain on a scale of 0-10, 0 = no pain/discomfort, 10 = worst pain imaginable. Please indicate by circling below:

Pain at its least: 0 1 2 3 4 5 6 7 8 9 10 Pain at its worst: 0 1 2 3 4 5 6 7 8 9 10

Describe the nature of your pain: ☐ Sharp ☐ Ache ☐ Numb ☐ Burning ☐ Throbbing ☐ Shooting

How often are your symptoms present?

☐ Constantly (76-100% of the day ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% if the day ☐ Intermittently (0-25% of the day)

In general, would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence	☐ Asthma	☐ Diabetes	☐ Currently Pregnant, # weeks___
☐ High Blood Pressure	☐ Epilepsy	☐ Stroke	☐ Pace Maker
☐ Dizziness/Fainting	☐ Back Injury	☐ Fracture	☐ Tobacco, freq: _____/day:
☐ Osteoporosis	☐ Arthritis	☐ Cancer	☐ Other: _____
☐ Cardiac Condition	☐ Depression	☐ Hepatitis	

Current Medications: _____

_____

I certify to the best of my ability, the above information is complete and accurate.

Patient/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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