Medical History Form

Patient Name:_____

Height:_____ft_____in Weight:_____ Date of injury:_____

Injury/Aliment: _____

How did this injury occur? _____

Have you been hospitalized for the present condition? ☐Yes ☐No If Yes, date: _____

Have you had surgery for the present condition? ☐Yes ☐ No If Yes, date: _____

If yes, surgery type:_____

Have you had any falls this past year? ☐Yes ☐No If Yes, how many?_____

Have you received previous treatment for this condition? ☐Yes ☐No If Yes, date: _____

If yes, please summarize:_____

Have you ever had any of the following? ☐EMG ☐CT SCAN ☐ MYELOGRAM ☐MRI ☐XRAY

Are you on any medications? Check if attached: □ Attached Please list: (you may use reverse side)

_____

_____

To help us understand your symptoms, please check all that apply.

My pain is worse:

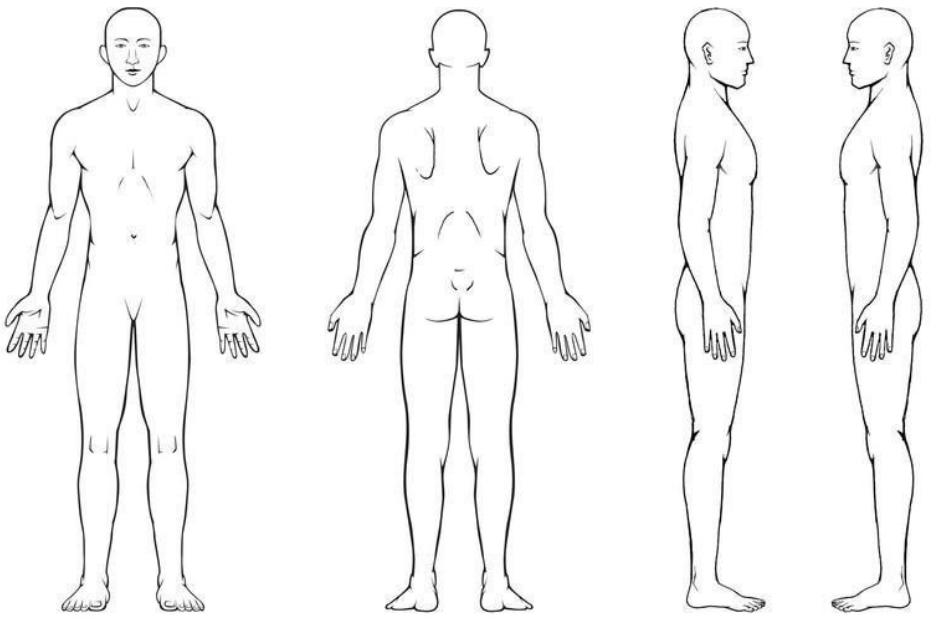
☐ in the morning	☐ constant
☐ during the day	☐ with activity
☐ at night	☐ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best_____and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



KEY

↑or↓: Radiating Pain
XXX: Spasm
ZZZ: Tenderness
///: Numbness/Tingling
000: Ache/Pain

Please continue to 2nd page

HORST PT
Strength. Mobility. Function.

Have you ever, or are you presently being treated for any of the following?

Acquired Respiratory Distress Syndrome	☐Yes	☐No	Allergies	☐Yes	☐No
Anxiety or Panic Disorders	☐Yes	☐No	Back Injury	☐Yes	☐No
Arthritis (RA, OA)	☐Yes	☐No	Bleeding Disorders	☐Yes	☐No
Asthma	☐Yes	☐No	Bowel / Bladder Abnormalities	☐Yes	☐No
Chronic Obstructive Pulmonary Disease (COPD)	☐Yes	☐No	Cancer	☐Yes	☐No
Skin Abnormalities	☐Yes	☐No	Defibrillator	☐Yes	☐No
Congestive Heart Failure (CHF)	☐Yes	☐No	Dizzy or Fainting Spells	☐Yes	☐No
Degenerative Disc Disease	☐Yes	☐No	Epilepsy or Seizure Disorder	☐Yes	☐No
Depression	☐Yes	☐No	Fracture	☐Yes	☐No
Angina	☐Yes	☐No	Headaches	☐Yes	☐No
Diabetes	☐Yes	☐No	Hepatitis A, B, C	☐Yes	☐No
Emphysema	☐Yes	☐No	Hernia	☐Yes	☐No
Hearing Impairment	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Heart Attack	☐Yes	☐No	HIV/AIDS	☐Yes	☐No
Multiple Sclerosis	☐Yes	☐No	Hypoglycemia	☐Yes	☐No
Osteoporosis	☐Yes	☐No	Immunosuppressant Condition	☐Yes	☐No
Parkinson's Disease	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Peripheral Vascular disease	☐Yes	☐No	Liver / Gallbladder Problems	☐Yes	☐No
Stroke or TIA	☐Yes	☐No	Metal Implants	☐Yes	☐No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	☐Yes	☐No	Nausea / Vomiting	☐Yes	☐No
Visual Impairment (cataracts, glaucoma, macular degeneration)	☐Yes	☐No	Pacemaker	☐Yes	☐No
Smoking	☐Yes	☐No	Pregnancy	☐Yes	☐No
Special Diet Guidelines	☐Yes	☐No	Ringing in Your Ears	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Sexual Dysfunction	☐Yes	☐No

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

_____

Signature of Patient or Guardian (if patient is a minor):_____Date: _____