

**Pillsbury Physical Therapy
Medical History**

Name: _____

Date: _____

Gender: M/F Age: ____

Have you received Physical Therapy this year? Y/N

Past Medical History: Please circle each condition that you have been told you have (or had).

Heart Disease

Congestive Heart Failure (CHF)
High Blood Pressure
Heart Attack (MI)
Atherosclerotic Disease (CAD)
Angioplasty

Valvular Disease
Stents
Arrhythmia
Coronary Artery Bypass Graft (CABG)
Angina

Lung Disease

Chronic Obstructive Pulmonary Disease (COPD)
Emphysema

Asthma
Recent Pneumonia

Vascular Disease

Peripheral Arterial Disease
Acquired Respiratory Distress Syndrome (ARDS)
Diabetes
Taking Blood Pressure Meds

Stroke/ TIA
Chronic Bronchitis
Hypertension

General Medical Conditions

Arthritis (rheumatoid/osteoarthritis)
Allergies
Neurological Disease (such as MS or Parkinson's)
Headaches
Gastrointestinal Disease (ulcer, hernia, reflux,
 bowel, liver, gall bladder)
Back Pain (neck pain, low back pain, degenerative
 disc disease, spinal stenosis)
Hepatitis/ AIDS
Prior Surgery(s) _____

Osteoporosis
Anxiety or Panic Disorders
Depression
Previous Accidents
Incontinence
Hearing Impairment (very hard of
 hearing, even with hearing aids)
Sleep Dysfunction
Prosthesis/Implants
Cancer

If you have circled any of the above, **Please briefly explain below:**

Do you take blood thinners? Yes/No Are you allergic to latex? Yes/No Do you smoke? Yes/ No

Do you have a pacemaker? Yes/No Are Pregnant? Yes/ No

Have you had a recent illness: Yes / No, if yes please explain:

Current Medications:

Occupation: _____

Work Status (circle one): Employed Unemployed Student: FT/ PT

How many days a week do you Exercise? _____

What date did your present pain start? _____

How (gradually, suddenly, injury)?

My symptoms are currently (circle one):

Getting Better About the same Getting Worse

What treatments have you received for this problem so far? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

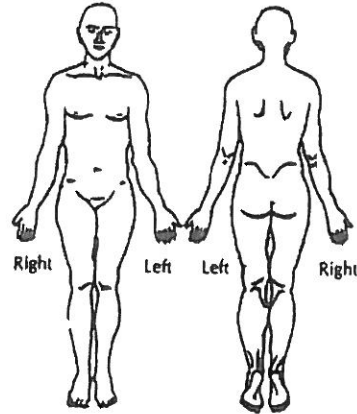
What are your personal goals for therapy at this time? _____

Have you had an x-ray, MRI, or other imaging study for this problem? Yes No

Thank You

Patient Signature _____ Date: _____

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Body Chart:

Please mark the areas where you feel pain on the chart to the right.

On the scale below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Please circle the number below which best represents your overall average level of function:

Cannot do Anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do Usual Functions**

*Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below and circle the number which best represents your ability:

1.) _____

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before injury

2.) _____

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before injury

3.) _____

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before injury

<p><u>For Therapist:</u> Rating: _____ Rating: _____ Rating: _____ AVG: _____</p>
