New Heights Performance
PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

Name_____ Date_____

Are you presently working? Y N Date of next physician's visit_____

Date of injury/onset_____ Have you experienced these symptoms before? Y N

Cause of injury: Auto Work Sports Unknown Other:_____

If work comp, currently working? Y N Restrictions? Y N Type of work_____

Do you have or have you had any of the following:

Diabetes	Y N	Hypoglycemia	Y N	Osteoarthritis	Y N
Chest Pain	Y N	Osteoporosis	Y N	High Blood Pressure	Y N
Hernia	Y N	Heart Disease	Y N	Rheumatoid Arthritis	Y N
Pacemaker	Y N	Seizures	Y N	Headaches/Migraines	Y N
Metal Implants	Y N	Kidney Problems	Y N	Dizziness/Fainting	Y N
Cancer	Y N	Fractures	Y N	Pelvic Floor Pain	Y N
Blood Disorder	Y N	Head Injury	Y N	Incontinence	Y N
Fibromyalgia	Y N	Jaw Pain/TMD	Y N	Liver/Gallbladder Problems	Y N
Depression	Y N	Bipolar	Y N	Anxiety disorder	Y N
Stroke	Y N	Ringing in Ears	Y N	Asthma/Breathing Difficulty	Y N

If you answered YES to any of the items above, please briefly explain and give the date.

Include any other pertinent information regarding your past medical history.

_____

_____

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If female, are you pregnant? Y N Estimated Due Date:_____

Do you have any allergies? Y N If yes, please list:_____

Are you presently taking any medication? Y N
If yes, please list what medication and for what condition_____

Do you participate in any sports, exercise program or activities on a regular basis: Y N

Please list: _____

Have you had any other treatment for this condition (currently or in the past)? Y N
If yes, please check:

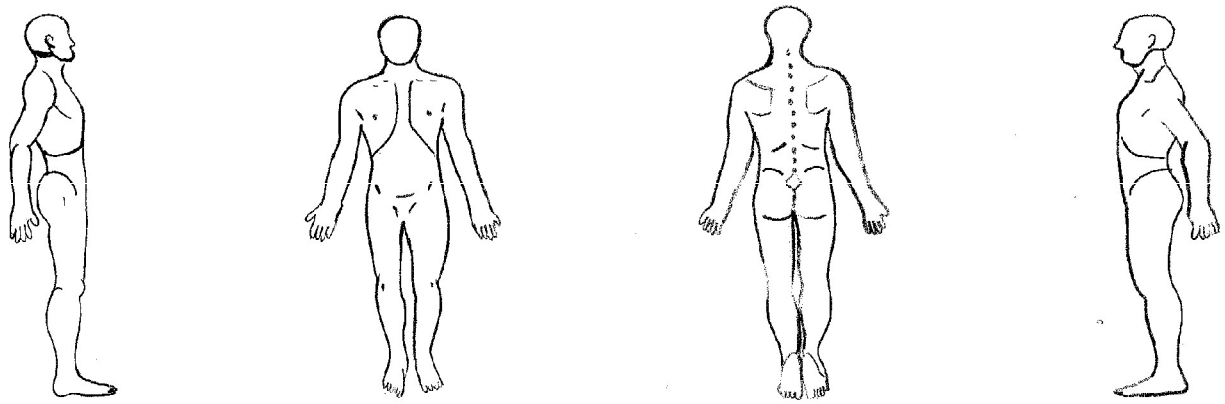
____Surgery ____Physical Therapy ____CT Scan

____Medications ____Chiropractic ____MRI

____Injections ____X-rays ____EMG/NCV

____Other: _____

Please indicate below where your symptoms are located using the key, below:
KEY: **Numbness:** ////////// **Tingling:** 0000000 **Pain:** XXXXXXX



Place an "X" on the line below indicating your pain at its lowest and highest levels.

No Pain 0 l____l____l____l____l____l____l____l____l____l____l 10 Worst Pain

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Current limitation (Please check all that apply)

____None

____Sitting

____Standing

____Sit to Stand

____Walking

____Lying Down

____Up/Down Stairs

____Bending

____Squatting

____Reaching

____Sleeping

____Taking a Deep Breath

____Talking/Chewing/Yawning

____Repetitive Activities

____Self Care/Hygiene

____Home management activities

____Sports/Recreation

What are your goals for physical therapy?_____

_____

_____

Patient/GuardianSignature:_____

Reviewed by therapist:___