LARRY HAM & ASSOCIATES PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Name: _____ **Referring Physician**: _____
Family Physician: _____

Date of Onset of Injury/Condition: _____

If this is a ***work related injury***, last date worked due to this injury: _____
Have you returned to work? □ No □ Yes - ____ Light Duty ____ Full Duty Date Returned to Work: _____

Have you had Surgery ***for this injury***? □ No □ Yes Type: _____
Took Place in a: □ Hospital □ Day Surgery Center Number of Surgeries ***for this injury***: _____

Are you taking ANY Prescription or Non-Prescription Medications ***for this injury***? □ No □ Yes
□ Anti-Inflammatory: _____ □ Muscle Relaxant: _____ □ Pain Meds: _____

Are you taking ANY Prescription or Non-Prescription Medications ***in general***? □ No □ Yes
Name(s): _____
Are you Allergic to ANY Medications? □ No □ Yes Name(s): _____

Have you had ANY of the following Medical Services or Treatment ***for this Injury/Condition***?

____ Emergency Room Care
____ General Practitioner/Family Practitioner
____ Neurologist
____ Orthopedist
____ Podiatrist
____ Chiropractor
____ X-Rays
____ CT Scan
____ MRI
____ Myelogram
____ Nerve Conduction Studies
____ Ultrasound
____ Acupuncture
____ Massage Therapy
____ Occupational Therapy
____ Physical Therapy
____ Other: _____
_____

General Health History: Do you now have OR have you ever had ANY of the following? (Just mark the "Yes" conditions)

____ Asthma, Bronchitis, or Emphysema
____ Shortness of Breath/Chest Pain
____ High Blood Pressure
____ Coronary Heart Disease or Angina
____ Heart Attack or Heart Surgery
____ Pacemaker
____ Congestive Heart Disease
____ Stroke/TIA
____ Blood Clot/Emboli
____ Epilepsy/Seizures
____ Hernia
____ Diabetes
____ Cancer – Location: _____
____ Infectious Disease – Type: _____
____ Arthritis: □ Rheumatoid □ Osteo
____ Osteoporosis
____ Bowel or Bladder Problems
____ Emotional/Psychological Problems
____ Sleeping Problems/Difficulty Sleeping
____ Severe OR Frequent Headaches
____ Numbness OR Tingling
____ Dizziness OR Fainting
____ Weight Loss OR Loss of Energy
____ General Weakness
____ Allergies
____ Do You Use Tobacco?
____ Pregnant - ____ weeks/months

Previous Injuries/Surgeries

____ Neck ____ Hip
____ Back ____ Knee
____ Shoulder ____ Leg
____ Elbow ____ Ankle
____ Hand ____ Foot

List any other information that would assist us in your care: _____

RIGHT NOW, how do you describe your OVERALL health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you aware of your diagnosis and prognosis as explained to you by your physician? □ No □ Yes
What are your expectations/goals while in physical therapy? _____

Would you like to speak to a social worker about any aspects of your rehabilitation program? □ No □ Yes

Patient/Guardian Signature: _____ **Date**: _____