MEDICAL HISTORY FORM

Today's Date: _____ /_____ /_____ (Please Print Clearly)

PATIENT INFORMATION		PHYSICIAN INFORMATION
Patient Name:		Referring Physician:
DOB: / /	Age:	Primary Physician:
		Date of Next Physician's Appointment:

CURRENT INJURY	
Body part(s) to be treated:	
Onset: Sudden ❒ Gradual ❒	**Date of Injury** *OR* **Duration of Symptoms**:
If you had an injury, **briefly** describe how the injury occurred:	
Have you had similar symptoms before: No ❒ Yes ❒ *If Yes, When:*_____	
Who have you seen for your current condition: Primary MD ❒ Orthopedic MD ❒ Other MD ❒ PT ❒ Chiropractor ❒	
What Tests or Procedures have been done for your current condition: X-Rays ❒ MRI/CT Scan ❒ Bone Scan ❒ EMG ❒ Blood Work ❒ Other ❒ _____	
What treatment has been performed for your current condition: No Treatment ❒ Medication ❒ Injection(s) ❒ PT ❒ Surgery ❒ Date: / /	
What medication(s) are you taking for your ***current*** condition (prescribed or over-the-counter): 1) _____ 2) _____ 3) _____ 4) _____	
What was your **primary** reason for choosing Fast Track Physical Therapy: ❒ MD Highly Recommended Fast Track ❒ MD Gave You Choice of Clinics ❒ Family/Friend Referred ❒ Insurance In-Network ❒ Convenient Location ❒ Website/Internet Search ❒ Starview/Philly Diner Placemat ❒ Stratford Fall Festival ❒ Yellow Pages Phonebook	

OCCUPATION	
What is your occupation: _____	**OR** ❒ Homemaker ❒ Retired ❒ Student
Are you currently employed: Yes ❒ No ❒	***If yes:*** F/T ❒ P/T ❒ Light Duty ❒ Temporary Out of Work ❒
My work primarily involves: Sitting ❒ Standing ❒ Light Labor ❒ Heavy Labor ❒	

HOBBIES OR LEISURE ACTIVITIES *(please list any **physical** hobbies or leisure activities)*

GENERAL FITNESS LEVEL				
How would you describe your current fitness level:	Excellent ❒	Good ❒	Fair ❒	Poor ❒
How often do you exercise weekly:	None ❒	1-2x ❒	3-4x ❒	5+ ❒
General Stress Level:	Low ❒	Moderate ❒	High ❒	Overwhelmed, feeling hopeless ❒

(Continued on Reverse)

FAST TRACK
Physical Therapy

PAST MEDICAL HISTORY (Please check "yes" if you have ever been diagnosed with…)

****Note: If you are unsure about a particular item, please leave it blank and discuss this with your therapist.*

	Yes	No
Auto-Immune Disease		
Systemic Arthritis (RA, Lupus, Other)	❒	❒
Unexplained rashes, sores, swelling	❒	❒
Fibromyalgia/Chronic Fatigue Syndrome	❒	❒
Blood Disorders		
Bleeding Disorders	❒	❒
Clotting Disorders	❒	❒
History of DVT (Blood Clots)	❒	❒
Currently taking blood thinners	❒	❒
Peripheral Vascular Disease	❒	❒
Cancer		
History of cancer: Type _____	❒	❒
Cardiovascular		
Heart Attack	❒	❒
Chest Pain or Angina	❒	❒
Exercise heart rate restrictions (per MD)	❒	❒
Do you have a pacemaker?	❒	❒
Endocrine/Metabolic		
Diabetes	❒	❒
Osteoporosis	❒	❒
Immunologic		
HIV	❒	❒
HEP B, HEP C	❒	❒

	Yes	No
Neurologic		
Stroke/TIA	❒	❒
MS/Parkinson's Disease	❒	❒
Seizure disorder	❒	❒
Poor balance w/frequent falls	❒	❒
Recent tremors or clumsy walking	❒	❒
Numbness/tingling both hands or feet	❒	❒
Pulmonary		
Asthma	❒	❒
Shortness of breath with exercise	❒	❒
Require the use of an inhaler	❒	❒
Other		
Currently pregnant (or think you might be)	❒	❒
Do you have metal implants?	❒	❒
Severe cold intolerance/Raynauds	❒	❒
Poor tolerance to NSAIDS	❒	❒
Severe food drug allergies	❒	❒
Vision or hearing difficulties	❒	❒
Constitutional Symptoms (Current)		
Fever/chills/night sweats	❒	❒
Severe fatigue/malaise	❒	❒
Nausea/vomiting	❒	❒
Dizziness/fainting	❒	❒
Unexplained weight loss, >10%	❒	❒

Other: Please include recent hospitalizations or any other information that you think would be beneficial in helping us with your care:

To the best of my knowledge, the information above is accurate.

Print Name: _____ Signature: _____ Date: _____

Relationship to Patient: _____