

Wallace Physical Therapy

ORTHOPEDIC-INDUSTRIAL-SPORTS-PERSONAL INJURY

MEDICAL HISTORY

NAME: _____ DATE: _____

Primary Care Physician: _____

Referring Physician: _____

Have you had surgeries for this injury: Y N

Type of Surgery: _____

Dates(s) of surgery (ies) for this injury: _____

Please list medications you're currently taking: _____

Have you had any of the following intervention for this injury?

Urgent Care _____

X-rays _____

CT Scan _____

MRI _____

EMG _____

OTHER _____

Chiropractor _____

Physical Therapy _____

Occupational Therapy _____

Orthopedist _____

Neurologist _____

Do you have or have you ever been treated for any of the following conditions:

Anemia _____

Allergies _____

Arthritis _____

Asthma _____

Back Injury _____

Blood Clots _____

Cancer _____

Diabetes _____

Dizziness _____

Epilepsy _____

Headaches _____

Heart Disease _____

Hernia _____

High Blood Pressure _____

Joint Replacement _____

Neck Pain _____

Numbness _____

Osteoporosis _____

Sleeping Disorder _____

Vision Problems _____

Weakness _____

Weight Loss _____

Are you pregnant? _____

Do you smoke? _____

Other: _____

I have reviewed the patient's medical history with him/her.

Therapist Signature: _____

Who may we thank for referring you to us? _____