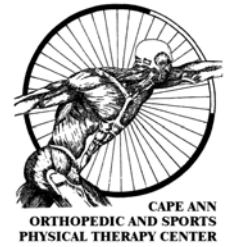


# CAPE ANN ORTHOPEDIC & SPORTS PHYSICAL THERAPY CENTER MEDICAL HISTORY HEALTH FORM



*If you do not understand a question, please ask your therapist for assistance*

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for your visit / Chief complaint:

\_\_\_\_\_

Primary Care Physician:

\_\_\_\_\_

Date of Last Physical Exam:

\_\_\_\_\_

Referring Physician: (if different from above)

\_\_\_\_\_

Date of Next Follow-up:

\_\_\_\_\_

Leisure Activities: \_\_\_\_\_

Are you currently being treated by any of the following:

Medical Doctor	Yes	No	Osteopath	Yes	No
Psychiatrist/psychologist	Yes	No	Dentist	Yes	No
Chiropractor	Yes	No	Other	_____	

**VERY IMPORTANT:** Have you seen a physical therapist within the past year? If so, why?

\_\_\_\_\_

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical examination, check up, etc.):

\_\_\_\_\_

Are you pregnant? Yes No If yes, how many weeks? \_\_\_\_\_

Have you or any immediate family member EVER been diagnosed with:

	<u>Self</u>		<u>Family</u>	
	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Type: _____				
Heart Problems	Yes	No	Yes	No
Circulation Problems	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Emphysema/Bronchitis	Yes	No	Yes	No
Chemical dependency (e.g. Alcoholism)	Yes	No	Yes	No
Thyroid problems	Yes	No	Yes	No
Multiple Sclerosis	Yes	No	Yes	No
Rheumatoid Arthritis	Yes	No	Yes	No
Other arthritic conditions	Yes	No	Yes	No
Depression	Yes	No	Yes	No
Hepatitis	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Kidney disease	Yes	No	Yes	No
Urinary tract infection	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No
Last Bone Density Test: _____				
Lyme / Tick-borne diseases	Yes	No	Yes	No

(Continued on reverse →)

	<b>Self</b>		<b>Family</b>	
	Yes	No	Yes	No
HIV	Yes	No	Yes	No
Anemia	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No
Headaches	Yes	No	Yes	No
Migraines	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Insulin Dependent?	Yes	No	Yes	No

Other Neurologic disorders: (ie. Cerebral palsy, Guillian Barre, Post Polio, TBI)

Please specify: \_\_\_\_\_

Please list any surgeries or other conditions for which you have been hospitalized along with the approximate date and reason (e.g. trauma/illness) for the hospitalization:

Date	Surgery/Condition	Reason
_____	_____	_____
_____	_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date	Injury	Date	Injury
_____	_____	_____	_____
_____	_____	_____	_____

What **Non-Prescription** medications have you taken in the last week? (e.g. Aspirin, Tylenol, Advil, antihistamine)

\_\_\_\_\_

Please list any **Prescription** medications that you are currently taking (including pills, injections or skin patches)

\_\_\_\_\_

How many cups of caffeinated beverages do you drink per day? \_\_\_\_\_  
 Do you or have you in the past smoked tobacco?      Yes      No  
 If yes, \_\_\_\_\_ Packs x \_\_\_\_\_ Years      Last tobacco use \_\_\_\_\_

In the past three months have you had or do you experience:

A change in your health?	Yes	No
Changes in appetite?	Yes	No
Menstrual irregularities?	Yes	No
Dizziness?	Yes	No
Difficulty swallowing?	Yes	No
Shortness of breath?	Yes	No
Changes in bladder and bowel?	Yes	No
Weight Loss/Gain?	Yes	No
Nausea/vomiting?	Yes	No
Fatigue?	Yes	No
Weakness?	Yes	No
Numbness/tingling?	Yes	No
Fever/chills/sweats?	Yes	No
Often bothered by feeling down, depressed or hopeless?	Yes	No
Been bothered by little interest or pleasure in doing things?	Yes	No

What are your goals for physical therapy? \_\_\_\_\_

\*\*\*\*\*

Next of kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Therapist reviewed form with patient?      Yes      No

Therapist's Signature: \_\_\_\_\_ Date \_\_\_\_\_