MEDICAL INFORMATION

Name_________________________ SS#:_____________ Date____________________

Date of Birth___________________ Age ________ M / F Ht : Wt:

Referring Physician________________________ PCP__________________________

Diagnosis for this visit____

Race: (circle all that apply)
Asian Native Hawaiian / Pacific Islander
Black Hispanic or Latino
White

Are there any customs or religious beliefs that might affect medical care? _______________

____

Education: (circle highest completed)
High school grade 9 10 11 12
Some college / technical school
College graduate
Graduate school / advanced degree

Learning Barriers: (circle all that apply)
none unable to read
vision unable to understand what is read
hearing language / needs interpreter
other_______________

List of all surgeries:

Accidents/Fractures/dislocations:

Allergies:

Date of last physical exam:

Functional Status / Activity Level
Do you have difficulty with the following activities? (circle all that apply)

Bed mobility
Transfers (bed to chair; bed to commode)
Walking on level surfaces
Walking on uneven terrain
Walking on stairs
Walking on ramps
Self care (bathing, dressing, eating, toileting
Home management (household chore, shopping)
Community activities such as school or work
Recreation or hobbies

Do you have a disability rating?
Location__________________________________

Date rating received__________________________

Rating percentage________%

Medications
a. List current prescription medications:
____

____

____

b. Do you take any nonprescription medications? (circle all that apply)
Advil/Aleve Decongestants
Antacids Herbal supplements
Ibuprofen/Naproxen Tylenol
Antihistamines Other
Aspirin

c. Have you taken any medications previously for the condition for which you are seeing the physical therapist?
yes no
If yes, please list:

Clinical Tests: Within the past year, have you had any of the following tests? If so, when?

Angiogram _______ Mammogram________
Arthroscopy ______ MRI _______________
Biopsy __________ Myleogram__________
Blood tests________ NCV ______________
Bone scan ________ Pap smear___________
Bronchoscopy _____ Pulmonary function ___
CT scan___________Spinal tap___________
Doppler ultrasound___Stool tests___________
Echocardiogram_____Stress test___________
EEG ______________Urine tests___________
EKG______________X-rays______________
EMG______________Other_______________