ElmTree
WELLNESS & PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

Name: _____ Treating Physician: _____
Family Physician: _____ Date of 1st Doctors Visit for this Injury: _____
Last Day Worked Due to this Injury (if applicable): _____
Date Returned to Work (if applicable): _____
Were you referred to Professional PT by: Surgeon Rehab MD Other

Have you had Surgery for this Injury? YES NO Number of Surgeries: 1 2 3 4 Other: _____
Type of Surgery: _____

Are You Currently Taking Any Prescription or Non-Prescription Medications: Yes No (Please List Below)

Anti-Inflammatories	Yes	No	_____
Muscle Relaxers	Yes	No	_____
Pain Medication	Yes	No	_____
Other	Yes	No	_____

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	____	____	General Practitioner	____	____
EMG/NCV	____	____	CT Scan	____	____
Massage Therapy	____	____	MRI	____	____
Milligram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room Care	____	____	X-Rays	____	____

Do you now or have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	High Blood Pressure	____	____	Anemia	____	____
Shortness of Breath/Chest Pain	____	____	Heart Attack or Surgery	____	____	Diabetes	____	____
Coronary Heart Disease or Angina	____	____	Thyroid Trouble/Goiter	____	____	Gout	____	____
Cancer/chemotherapy/Radiation	____	____	Dizziness or Fainting	____	____	Weakness	____	____
Emotional/Psychological Problems	____	____	Infectious Diseases	____	____	Hernia	____	____
Bowel or Bladder Problems	____	____	Numbness or Tingling	____	____	Allergies	____	____
Severe or Frequent Headaches	____	____	Elbow/Hand Injury	____	____	Osteoporosis	____	____

Vision or Hearing Difficulties	____	____	Neck Injury/Surgery	____	____	Stroke/TIA	____	____
Sleeping Problems/Difficulties	____	____	Back Injury/Surgery	____	____	Blood Clot/Emboli	____	____
Leg/Ankle/Foot Injury/Surgery	____	____	Knee Injury/Surgery	____	____	Epilepsy/Seizures	____	____
Do you have a Pacemaker?	____	____	Arthritis/Swollen Joints	____	____	Varicose Veins	____	____
Any Pins or Metal Implants?	____	____	Are You Pregnant?	____	____	Joint Replacement	____	____
Weight Loss/Energy Loss	____	____	Do You Smoke?	____	____			

Please list any additional information that would assist us in providing you care?

_____

_____

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

Based upon your awareness of your diagnosis, what are your expectations/goals while in this program?

_____

Patient/Guardian Signature: _____ Date: _____

Therapist Signature:_____ Date: _____