CENTENNIAL
SPORTS & PHYSICAL THERAPY

Medical History Form

Welcome to Centennial Sports and Physical Therapy. Please take a moment to complete your medical history as ***accurately*** *as possible. This information allows us to provide you with the most efficient and effective care specific to your personal needs. Thank You*

Name: ___________________________________Age:_______ Occupation: ______________________________________

Date of injury/onset: _________________________Leisure activities: ____

How were you injured? ____

Patient's Chief Complaint:____

Surgeries related to this injury? ☐ No ☐ Yes procedure: _______________________ Date of Surgery: _____________

Please list any surgeries or other conditions that we should be aware of: ____

Tests (X-ray, MRI):__________________________________

Are you **sensitive to latex?** ☐ Yes ☐ No Do you have a **Pacemaker**? ☐ Yes ☐ No

Do you **Smoke**? ☐ Yes ☐ No

Do you **exercise** regularly? ☐ Yes ☐ No Times a week______________ Specific exercise____________________

Have you ever taken **steroid** medication for any medical conditions? ☐ Yes ☐ No

Have you ever taken **blood thinning** or **anticoagulant** medications for any medical conditions? ☐ Yes ☐ No

Have you RECENTLY noted any of the following *(check all that apply)*?

☐ Balance issues while walking
☐ Bowel / Bladder changes
☐ Constipation
☐ Cough
☐ Diarrhea
☐ Difficulty swallowing
☐ Dizziness / Lightheadedness
☐ Fainting
☐ Falls
☐ Fatigue
☐ Fever / Chills / Night sweats
☐ Headaches
☐ Heartburn / Indigestion
☐ Nausea or vomiting
☐ Numbness or tingling
☐ Shortness of breath
☐ Vision or hearing problems
☐ Weakness
☐ Weight loss or gain

Have you EVER been diagnosed with any of the following conditions *(check all that apply)*?

☐ Allergies___________________
____
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bladder/Urinary tract infection
☐ Blood Clots
☐ Bowel or bladder problems
☐ Bone or joint infection
☐ Cancer
☐ Chemical dependency
☐ Chest pain / Angina
☐ Circulation problems
☐ Depression
☐ Diabetes
☐ Emphysema / Bronchitis
☐ Eye problems / Infection
☐ Fibromyalgia
☐ Heart Problems
☐ Hepatitis
☐ High blood Pressure
☐ Kidney Disease
☐ Liver problems
☐ Lung problems
☐ Multiple Sclerosis
☐ Numbness or tingling
☐ Osteoporosis / Osteopenia
☐ Pelvic inflammatory disease
☐ Reproductive condition/Change
☐ Seizures
☐ Stroke
☐ Thyroid problems
☐ Ulcers
☐ Other: ____________

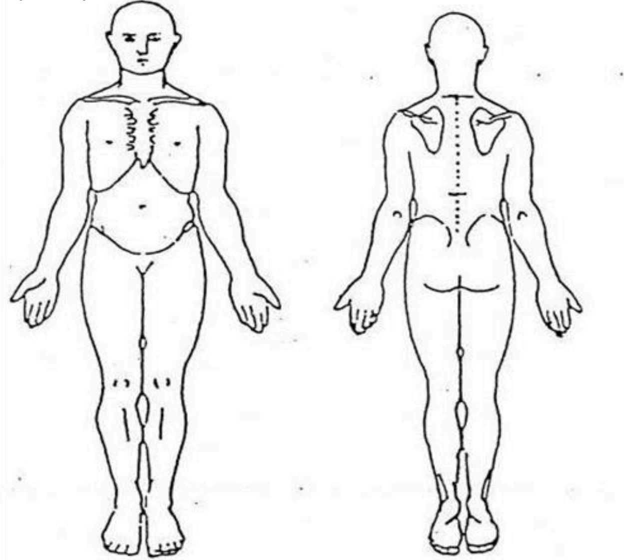
During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No
During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

Are you currently taking any **medications**? ***(Please list or attach a list)***

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Please use the diagram below to mark where you feel your symptoms and comment as you see appropriate, on the space provided



My symptoms currently: ☐ Come & Go ☐ Are Constant ☐ Are constant but change with activity

My symptoms are currently: ☐ Getting better ☐ Getting Worse ☐ Staying about the same

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Evening ☐ Night ☐ At rest ☐ After Exercise

When are your symptoms best? ☐ Morning ☐ Evening ☐ Night ☐ At rest ☐ After Exercise

Are there any other activities you are unable to do or are having difficulty with as a result of your problem? List & rate on the scale: **(Unable to perform** 0 1 2 3 4 5 6 7 8 9 10 **(Able to perform activity at pre-injury level)**

1)____ Rating: ________

2)____ Rating: ________

3)____ Rating: ________

Patient Specific Functional Scale (PSFS) Avg: _______

How did you decide to attend Centennial Sports and Physical therapy?

___Doctor ___Return Client __Friend or Relative ___Advertisement Other:____________________