CENTENNIAL SPORTS & PHYSICAL THERAPY

Dx:

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 enables us to deliver the most efficient and effective care tailored to your individual 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	Fainting	Numbness or tingling
Bowel / Bladder changes	Falls	Shortness of breath
Constipation	Fatigue	Vision or hearing problems
Cough	Fever / Chills / Night sweats	Weakness
Diarrhea	Headaches	Weight loss or gain
Difficulty swallowing	Heartburn / Indigestion	
Dizziness / Lightheadedness	Nausea or vomiting	

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

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

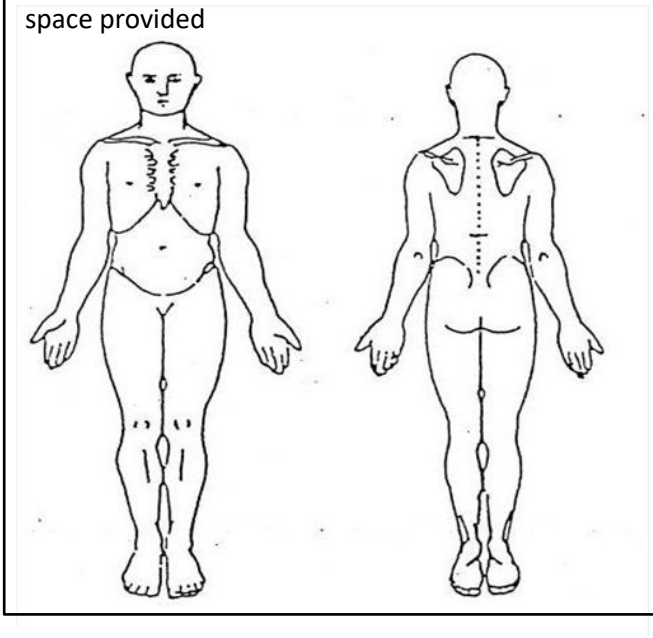
During the past month have you been feeling down, depressed or hopeless? Yes No

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 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:_____