

SPECHT PHYSICAL THERAPY MEDICAL HISTORY FORM

PATIENT INFORMATION		PHYSICIAN INFORMATION	
Patient Name:		Primary Physician:	
Date: / /	Age:	Referring Physician:	

CURRENT INJURY	
Body part(s) to be treated:	
Onset: Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Date of injury <i>OR</i> Duration of symptoms:	
If you had an injury, <u>briefly</u> describe how the injury occurred:	
Have you had a similar symptoms before: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Who have you seen for your current condition: Primary MD <input type="checkbox"/> Orthopedic MD <input type="checkbox"/> Other MD <input type="checkbox"/> PT <input type="checkbox"/> Chiropractor <input type="checkbox"/>	
What Tests or Procedures have been done for your current condition: X-Rays <input type="checkbox"/> MRI/CT Scan <input type="checkbox"/> Bone Scan <input type="checkbox"/> EMG <input type="checkbox"/> Blood Work <input type="checkbox"/> Other <input type="checkbox"/>	
What Treatment has been performed for your current condition: No Treatment <input type="checkbox"/> Medication <input type="checkbox"/> Injection(s) <input type="checkbox"/> PT <input type="checkbox"/> Surgery <input type="checkbox"/> date: / /	
What medications are you taking for your current condition (prescribed or over the counter): 1) _____ 2) _____ 3) _____ 4) _____	
What was your <u>primary</u> reason for choosing Specht.PT: <input type="checkbox"/> Doctor highly recommended <input type="checkbox"/> On doctor's list of clinics <input type="checkbox"/> Family/Friend <input type="checkbox"/> Insurance In-Network <input type="checkbox"/> Convenient location <input type="checkbox"/> Website/On-line review	

OCCUPATION	
What is your occupation: _____	<input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Student
Are you currently employed (excluding homemaker): Yes <input type="checkbox"/> No <input type="checkbox"/> <i>if yes</i> F/T <input type="checkbox"/> P/T <input type="checkbox"/>	
My work primarily involves: Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/>	

HOBBIES OR LEISURE ACTIVITIES <i>(please list any physical hobbies or leisure activities)</i>

GENERAL FITNESS LEVEL	
How would you describe your current fitness level: Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>	
How often do you exercise weekly: None <input type="checkbox"/> 1-2x <input type="checkbox"/> 3-4x <input type="checkbox"/> 5+ <input type="checkbox"/>	
General stress level: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> Overwhelmed, feeling hopeless <input type="checkbox"/>	

(Continued on Reverse)

PAST MEDICAL HISTORY (Please check “yes” if you have ever been diagnosed with...)

Note: If you are unsure about a particular item, please leave it blank and discuss this with your therapist

	Yes	No		Yes	No
Systemic Disorders			Neurologic		
Systemic Arthritis (RA, Lupus, Other)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained rashes, sores or swelling	<input type="checkbox"/>	<input type="checkbox"/>	MS/Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia/ Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Poor balance with frequent falls	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders			Recent tremors or clumsy walking	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling both hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>			
History DVT (Blood Clots)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary		
Currently taking blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath with exercise	<input type="checkbox"/>	<input type="checkbox"/>
			Require the use of an inhaler	<input type="checkbox"/>	<input type="checkbox"/>
Cancer			Other		
History of cancer, any type	<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant (or think you might be)	<input type="checkbox"/>	<input type="checkbox"/>
			Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Do you have metal implants	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Severe cold intolerance/Raynauds	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or Angina	<input type="checkbox"/>	<input type="checkbox"/>	Poor tolerance to NSAID's	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Severe food or drug allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart rate restrictions w/ ex. (per MD)	<input type="checkbox"/>	<input type="checkbox"/>	Vision or hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine/Metabolic			Constitutional symptoms (Current)		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Fever/ chills/ nights sweats	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Severe fatigue/malaise	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Immunologic			Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss, >10% BW	<input type="checkbox"/>	<input type="checkbox"/>
HEP B, HEP C	<input type="checkbox"/>	<input type="checkbox"/>			

Other: please include recent hospitalizations or any other information that you think would be beneficial in helping us with your care:

To the best of my knowledge, the information above is accurate.

Signature: _____

Date: _____

Relationship to Patient: _____