Name: _____

Date: _____

Carefree PHYSICAL THERAPY

MEDICAL HISTORY FORM

Do you have, or have you had any of the following?

GENERAL
- ☐ Currently pregnant
- ☐ Autoimmune disorder
- ☐ Cancer _____
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Allergies

EYES
- ☐ Loss of vision
- ☐ Eye pain
- ☐ Glasses/contacts

EARS/NOSE/THROAT
- ☐ Hearing impairment
- ☐ Ringing in your ears
- ☐ Difficulty swallowing
- ☐ Hearing aides

GASTROINTESTIAL
- ☐ Nausea
- ☐ GERD
- ☐ Gallbladder problems

SURGICAL
- ☐ Joint replacements
- ☐ Orthopedic surgery
- ☐ Heart surgery
- ☐ Spinal surgery
- ☐ Other surgeries _____

GENITOURINARY
- ☐ Incontinence
- ☐ Kidney disease
- ☐ Bladder/bowel disorder

MOOD
- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Chemical dependency

HEMATOLOGY
- ☐ Anemia
- ☐ Clots
- ☐ Lymphedema

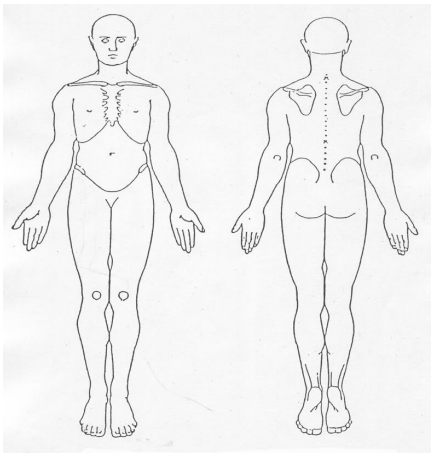
MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Fractures
- ☐ Muscular disease
- ☐ Metal implants
  Where _____
- ☐ Osteoporosis

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema/Bronchitis
- ☐ COPD
- ☐ Shortness of breath

TOBACCO USE
- ☐ Currently use Tobacco
- ☐ Do Not Use Tobacco Products

NEUROLOGICAL
- ☐ Seizures
- ☐ Stroke/CV
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Headaches
- ☐ Memory loss
- ☐ Neuropathy
- ☐ Dizziness

CARDIOVASCULAR
- ☐ Cardiac pacemaker
- ☐ Circulatory problems
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Abnormal heart beat
- ☐ Fainting
- ☐ Congestive heart failure



Please mark areas of pain.

PAIN/SYMPTOMS

Please mark the pain on an average day by marking a number on the scale below.

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

(No pain) (Severe)

Pain description:
- ☐ Intermittent
- ☐ Constant
- ☐ Ache
- ☐ Sharp
- ☐ Burning
- ☐ _____

MEDICARE PATIENTS ONLY

1. Have you fallen in the past year? ☐ yes ☐ no
2. Did you have an injury from a fall in the past year? ☐ yes ☐ no
3. Have you had 2 or more falls in the past year? ☐ yes ☐ no

Patient height _____

Patient weight _____