

JONES PHYSICAL THERAPY, PLC

“Encouraging Great Comebacks”

PATIENT MEDICAL HISTORY

GENERAL HEALTH STATUS: (Rate your over all health) Excellent Good Fair Poor

FAMILY HISTORY: (Check box if anyone in your family has or had any of these)

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pulmonary/Lung Disease |

SOCIAL/HEALTH HABITS:

Do you Smoke Tobacco? No Yes Occasionally Daily Socially
Do you Drink Alcohol? No Yes Occasionally Daily Socially

SURGICAL HISTORY: (List the most recent to 5 years)

- NO SURGERIES TO DATE
- | | |
|-------|------------|
| _____ | DATE _____ |
| _____ | DATE _____ |
| _____ | DATE _____ |
| _____ | DATE _____ |

DIAGNOSTIC TESTING FOR THIS INJURY/EPISODE: (Check all that apply)

- MRI CT Scan EMG/NVC Other: _____

WHO HAVE YOU SEEN FOR THIS INJURY/EPISODE:

- (Check all that apply)
- Emergency Room Care
 - General Practitioner
 - Physical Therapist
 - Occupational Therapist
 - Chiropractor
 - Massage Therapist
 - Orthopedist
 - Podiatrist
 - Neurologist
 - Other: _____

HAVE YOU EVER HAD PHYSICAL OR OCCUPATIONAL THERAPY?

When? _____
Where? _____
For How Long? _____

HAVE YOU EVER BEEN SEEN BY A CHIROPRACTOR?

When? _____
Where? _____
For How Long? _____

CURRENT MEDICATIONS:

NON-PRESCRIPTION:

PRESCRIPTION:

Do you have a Pacemaker? Yes No
Are you Pregnant? Yes No

MEDICAL HISTORY CHECKLIST(Check if you have or have had)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disorders |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Lyme’s Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Parkinson’s Disease | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Infections | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Other: _____ | |

By signing this form I agree that the information given is true.

Signature _____ Therapist _____ Date _____
Patient Date of Birth: _____