Maeske
Sports & Physical Therapy

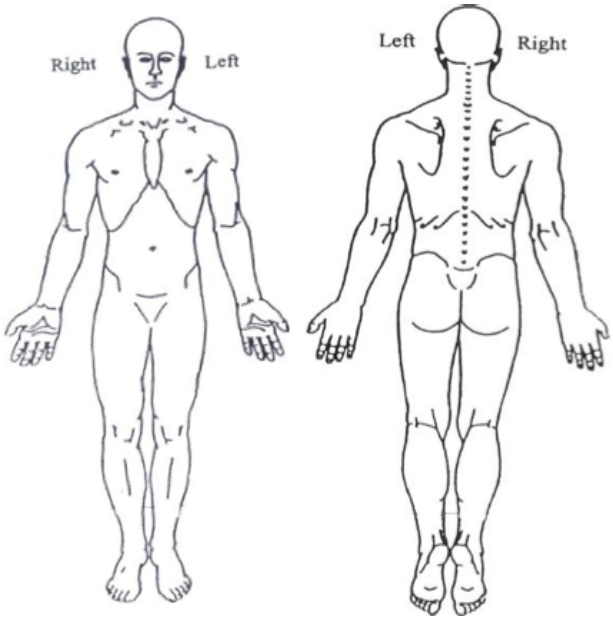
MEDICAL HISTORY

Name: _____ Surgery/Date:_____
Date of Birth: _____ Gender: M / F Occupation/School:_____
Age:_____ Hand Dominance: L / R Height:_____Weight:_____
Date of Onset/Injury:_____ Sport: _____

What brings you to physical therapy? _____

Have you had any Imaging? ☐ X-ray ☐ Bone Scan ☐ MRI ☐ CT Scan

Please identify your problem area on the diagram→.



Since it started, the pain is: (Circle One):

☐ Getting Worse ☐ Improving ☐ Staying The Same

Describe your pain: (Mark all that apply)

☐ Sharp ☐ Dullness ☐ Aching ☐ Burning
☐ Throbbing ☐ Shooting ☐ Cramping ☐ Stabbing
Other:_____

Changes in Bowel and Bladder Function? Yes / No

Difficulty with Cough/Sneeze/or Straining? Yes / No

Do wake from sleep due to pain? Yes / No

Do you have any Tingling, Numbness or Loss of Skin Sensation? Yes / No

Rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine). Please Circle.

Pain Right Now:	0	1	2	3	4	5	6	7	8	9	10
Pain at Best:	0	1	2	3	4	5	6	7	8	9	10
Pain at Worst:	0	1	2	3	4	5	6	7	8	9	10

Is there anything that makes you feel better/reduces your pain?_____
_____
_____

How would you rate your current health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you have problems with ☐ Hearing ☐ Vision ☐ Communication ☐ None

Are you currently: **Pregnant?** Yes / No **Stressed?** Yes / No **Depressed?** Yes / No

Please check if you have any of the following conditions:

- ☐ Smoke/Chew Tobacco
  Packs per Day: ____
- ☐ Use of Illegal Substances
- ☐ Drink Alcohol
  Amount per Week: _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Acid Reflux or Ulcers
- ☐ Thyroid Disorder
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Cardiac Bypass
- ☐ Cardiac Stents
- ☐ Sexually Transmitted Disease
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis or Osteopenia
- ☐ Metal/Plastic Implants
- ☐ Headaches or Migraines
- ☐ Dizziness or Fainting
- ☐ Nausea
- ☐ Pacemaker
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ Kidney Disease
- ☐ History of Stroke
- ☐ Depression
- ☐ Cancer (Site: _____)
- ☐ Recent Infection
- ☐ Recent Blood Thinning Medication
- ☐ Corticosteroid Use
- ☐ Angina/Chest Pain
- ☐ Bleeding Disorder
- ☐ Seizures/Epilepsy
- ☐ Diabetes (Type:_____)

In the past 3 months have you experienced any of the following?

- ☐ Changes in hearing
- ☐ Changes in mental abilities
- ☐ Frequent or severe headaches with no history of injury
- ☐ Swallowing or changes in speech
- ☐ Changes in vision (blurriness or loss of sight)
- ☐ Problems with balance, coordination or falling
- ☐ Fainting spells
- ☐ Persistent pain at night
- ☐ Fevers, chills or night sweats
- ☐ Unexplained weight loss
- ☐ Unwarranted fatigue
- ☐ Unusual lumps or growths
- ☐ Pulsating pain anywhere in your body
- ☐ Constant and severe pain in leg or arm
- ☐ Swelling without a history of injury
- ☐ Shortness of breath
- ☐ Frequent or severe abdominal pain
- ☐ Frequent nausea or vomiting

Please list ALL Medications/Supplements/Vitamins you are taking:

_____

_____

_____

Please list ALL previous Surgeries and dates:

_____

_____

_____

What are your Goals for Physical Therapy?_____

_____

_____

_____