

**Northwoods Therapy Associates**  
**Patient Medical History Form**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Job Duties \_\_\_\_\_

Employment Status (full-time, part-time, light duty, etc): \_\_\_\_\_

Referring Physician \_\_\_\_\_

Regular Physician \_\_\_\_\_

Date of onset of problem/injury/surgery \_\_\_\_\_

Sports/Recreational Activities/Hobbies \_\_\_\_\_

Please **provide name** of any of the following healthcare professionals you have seen within the **last year**:

Medical Doctor \_\_\_\_\_

Chiropractor \_\_\_\_\_

Occupational Therapist \_\_\_\_\_

Physical Therapist \_\_\_\_\_

Dentist \_\_\_\_\_

OTHER \_\_\_\_\_

If you have seen any of these **within the last year** please describe for what reason:

\_\_\_\_\_  
\_\_\_\_\_

Have you fallen down in the last year?    Yes    No    Were you injured?    Yes    No

Have you **EVER** been diagnosed with any of the following conditions? Please check those that apply.

_____ Cancer	_____ Multiple Sclerosis	_____ Osteoporosis
_____ Heart problems	_____ Rheumatoid arthritis	_____ Emphysema/Bronchitis
_____ MI (heart attack)	_____ Other arthritic conditions	_____ Tuberculosis
_____ Pacemaker	_____ Metal implants	_____ Hepatitis
_____ High blood pressure	_____ Allergy to latex	_____ Kidney disease
_____ Diabetes	_____ Other allergies	_____ Epilepsy/Seizure
_____ Asthma	_____ Stroke	_____ Hernia
_____ Anxiety	_____ Anemia	_____ Surgery
_____ Chemical Dependency	_____ Thyroid problems	_____ Other

If **YES** to any of the above please provide explanation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you currently pregnant?    YES    NO    Due Date (if yes) \_\_\_\_\_

Do you smoke or use chewing tobacco?    YES    NO    If yes, packs per day? \_\_\_\_\_

Please list **ANY** surgeries or other conditions that you have been treated for or hospitalized for.

Please provide approximate date and reason for any surgery or hospitalization.

Date	Surgery/Hospitalization	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check any **OVER THE COUNTER** medications you have taken within the last month?

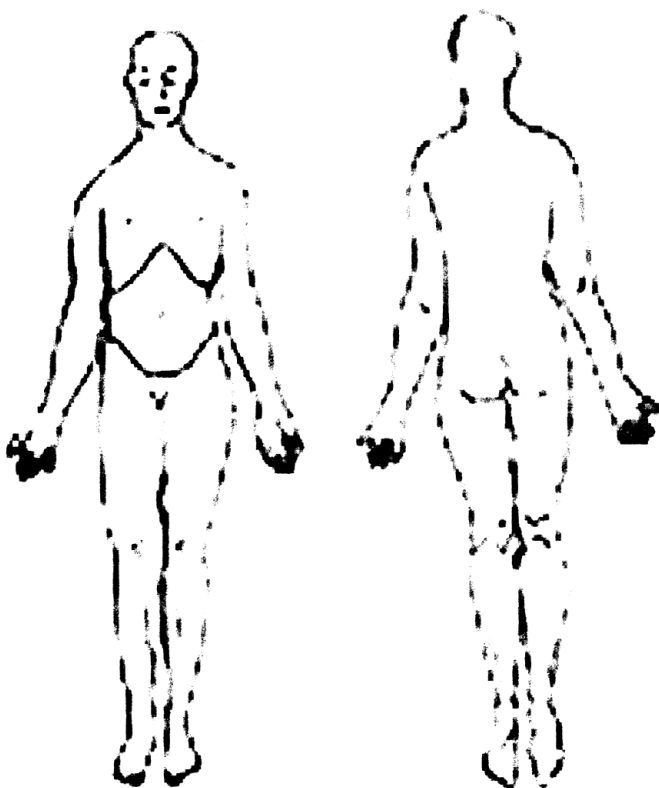
- |                    |                                    |
|--------------------|------------------------------------|
| _____ Aspirin      | _____ Decongestants                |
| _____ Tylenol      | _____ Antihistamines               |
| _____ Advil/Motrin | _____ Antacid                      |
| _____ Ibuprofen    | _____ Vitamins/mineral supplements |
| _____ Laxatives    | _____ Glucosamine & Chondroitin    |
|                    | _____ OTHER: _____                 |

Please list all **PRESCRIPTION** medications you are currently taking and dosage if known.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Please mark the diagram with your symptoms in the appropriate location.

- xxxx Pain
- //////// Numbness
- ^^^^^^ Tingling, asleep, abnormal

Please rate your pain on a scale of 0 to 10: \_\_\_\_\_  
(0 being no pain, 10 worst pain)

Please list any other information that would assist us with your care:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient signature \_\_\_\_\_ Today's date \_\_\_\_\_