Northwoods Therapy Associates

Patient Medical History

Name _____ Date _____
Date of Birth _____ Age _____ Height _____ Weight _____
Occupation/Employer _____
Job Duties _____
Employment Status (full-time, part-time, light duty, etc.) _____

Referring Physician _____
Regular Physician _____

Have you been seen in physical therapy or speech therapy at all this year? Yes No

If so, how many visits? _____

Are you currently receiving any home health care services? Yes No

Please rate your pain on a scale of 0 – 10

(0 = no pain, 10 = worst pain)

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

Date of onset of problem/injury/surgery_____
Sports/Recreational Activities/Hobbies _____

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?

_____ Cancer
_____ Heart Problems
_____ MI (Heart Attack)
_____ Pacemaker
_____ High blood pressure
_____ Diabetes
_____ Asthma
_____ Anxiety
_____ Chemical dependency
_____ Other arthritic conditions
_____ Metal implants
_____ Allergy to latex
_____ Ehlers Danlos
_____ Rheumatoid Arthritis
_____ Multiple Sclerosis
_____Other allergies
_____Stroke
_____Anemia
_____Thyroid problems
_____Osteoporosis
_____Hepatitis
_____Kidney Disease
_____ Epilepsy/Seizure
_____ Hernia
_____ Fibromyalgia
Other: _____

Have you experienced any of the following?

_____Weakness
_____ Stiffness
_____ Numbness
_____ Spasms
_____ Difficulty walking
_____ Balance deficits
_____ Swelling
_____ Tenderness
_____ Impaired wound healing
_____ Dizziness

If yes to any of the above, please provide an explanation:

_____
_____

Please list all PRESCRIPTION medications and dosages you are currently taking:

Name of Medication:	Dosage:	Route: (please circle one)
_____	_____	oral topical injection
_____	_____	oral topical injection
_____	_____	oral topical injection
_____	_____	oral topical injection
_____	_____	oral topical injection

Please list ANY surgeries or other conditions that you have been treated/hospitalized for. Please provide approximate date and reason for any surgery/hospitalization.

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

Are you currently pregnant? Yes No If yes, due date _____
Do you smoke or use chewing tobacco? Yes No If yes, pack per day _____

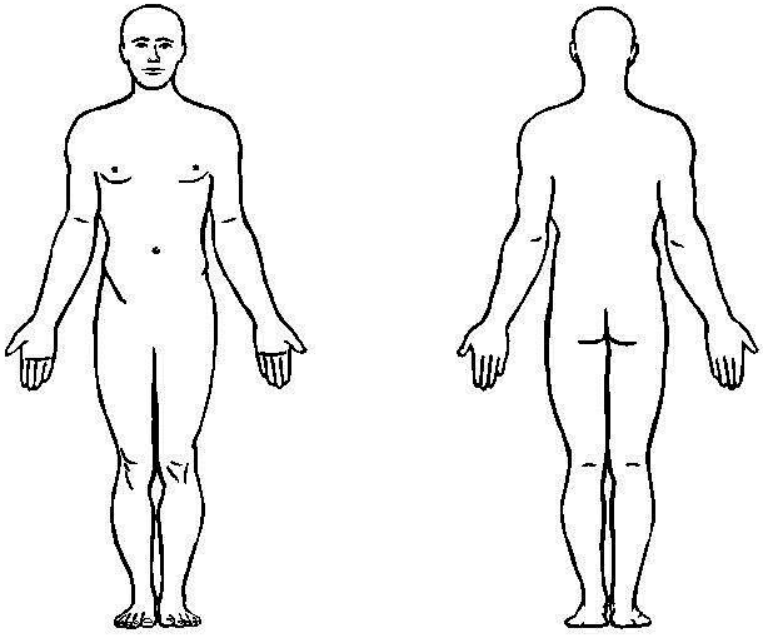
Check any OVER THE COUNTER medications you have taken within the last month:

_____Aspirin _____Tylenol _____Advil/Motrin _____Ibuprofen _____Laxatives

_____Decongestants _____Antihistamines _____Antacid _____Vitamins/supplements

_____Glucosamine & Chondroitin Other _____

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



xxxxxx Pain

////////// Numbness

^^^^^^^ Tingling, asleep, abnormal

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

_____
_____
_____

Patient Signature _____ Date _____