



**OUTPATIENT INFORMATION/MEDICAL HISTORY**

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

WORKING (Circle One): YES / NO DUE TO INJURY / DO NOT WORK / RETIRED

REASON FOR PHYSICAL THERAPY: \_\_\_\_\_

DATE OF ONSET: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

EMERGENCY CONTACT: NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

- Please list any significant procedures (surgeries or other conditions for which you may have been hospitalized). Please include date and reason for surgery or hospitalization: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Please complete attached list of medications you are currently taking, over the counter and/or prescription

- Please list any allergies you have: \_\_\_\_\_

- Please list any significant diagnoses (current medical conditions) you currently have: \_\_\_\_\_

**FUNCTIONAL PROBLEMS** (please circle any that apply to your diagnosis):

- |          |              |                                  |              |
|----------|--------------|----------------------------------|--------------|
| Sitting  | Squatting    | Reaching/Raising Arms            | Turning Head |
| Standing | Sleeping     | Driving                          | Speech       |
| Walking  | Dressing     | Working                          | Swallowing   |
| Stairs   | Bathing      | Lifting                          | Coughing     |
| Bending  | House Chores | Transferring sitting to standing | Memory       |

- Explain any other functional problems you may have due to this diagnosis \_\_\_\_\_  
\_\_\_\_\_



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**PAIN LEVEL**

- What level of pain does your current condition cause you? (please circle the number(s) below that apply)

No pain 0    1    2    3    4    5    6    7    8    9    10 Worst imaginable  
pain

- What word(s) best describe your pain (please circle any that apply):  
 dull    aching    sharp    burning    Other\_\_\_\_\_

- Do you also experience any other symptoms such as (please circle any that apply): tingling  
 numbness    stiffness    weakness    Other\_\_\_\_\_

- What do you hope to gain from treatment? \_\_\_\_\_

**MEDICAL TESTING**

- Have you had any x-rays, sonograms, CT scans, MRI done recently? \_\_\_\_\_Y \_\_\_\_\_N (If yes, at which facility did you have them done and what were the results?)\_\_\_\_\_
- 

- **Are you currently seeing any of the following?**

Psychiatrist/Psychologist \_\_\_\_\_Y \_\_\_\_\_N    Chiropractor \_\_\_\_\_Y \_\_\_\_\_N

Occupational therapist \_\_\_\_\_Y \_\_\_\_\_N    Speech therapist \_\_\_\_\_Y \_\_\_\_\_N

**\*\*\*\*Are you currently receiving home health nursing or therapy? \_\_\_\_\_Y \_\_\_\_\_N**

**\*\*\*\*Please state if you have received outpatient physical, occupational or speech therapy anytime earlier this year. \_\_\_\_\_**



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**PAST MEDICAL HISTORY:** Have you ever been told you have any of the following?

**Circle one**

- 1. Cancer YES NO
- 2. Diabetes YES NO
- 3. Osteoporosis YES NO
- 4. Osteoarthritis (OA) YES NO
- 5. Rheumatoid Arthritis (RA) YES NO
- 6. Hypertension / high blood pressure YES NO
- 7. Heart disease YES NO
- 8. Angina / chest pain YES NO
- 9. Shortness of breath YES NO
- 10. Stroke YES NO
- 11. Currently Pregnant YES NO
- 12. Asthma YES NO
- 13. Abnormal heart rhythm YES NO
- 14. Metal Implants YES NO
- 15. Chronic bronchitis YES NO
- 16. Pacemaker YES NO
- 17. Emphysema YES NO
- 18. Seizures / epilepsy YES NO
- 17. Any other medical issues (please explain) \_\_\_\_\_

- When is your next doctor's appointment? \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_





**REHABILITATION SERVICES  
BODY CHART**

Date: \_\_\_\_\_

Please mark the areas on the body chart where you are having problems/ symptoms.

