Schertz Parkway Physical Therapy
Patient Medical History Form

Name:_____ DOB:_____
Date of Injury: _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

Patient Medical History: (please circle any condition for which you have received treatment. Items not circled understood to be negative.)

High Blood Pressure	Asthma	Recent Weight Loss/ Gain
Heart Problem	Emphysema	Thyroid Problem (Hyper or Hypo)
Abnormal Heart Rate	Chronic Lung Problem	
Pacemaker	Chronic Heartburn	Diabetes (medical dependent? _____)
Heart Palpitations	History of Ulcers	
Angina (chest pain)	High Cholesterol	Cancer (where?_____)
Heart Murmur	Bowel or Bladder Problems	Epilepsy/ Seizure
Abnormal Bleeding	AIDS/ HIV Positive	

Other:_____

Do you have a history of fractures?	YES NO	Where? _____
Do you have a history of back/ neck pain?	YES NO	When?_____
Do you have any metal implants?	YES NO	Where?_____
Do you smoke?	YES NO	How much per day? _____
Do you exercise regularly?	YES NO	How often?_____
Do you have known drug allergies?	YES NO	Please list_____
Are you pregnant or suspect pregnancy?	YES NO	

In regards to your current today: please rate your pain none [0-1-2-3-4-5-6-7-8-9-10] worst

Do you have any "pins and needles" or numbness in your extremities?	YES NO
Do you have any weakness in your arms or legs?	YES NO
Do you have any coordination or balance problems?	YES NO
Do you have difficulty walking?	YES NO
Do you experience dizziness of vertigo with a change in position?	YES NO
Have you experienced headaches as a result of your condition?	YES NO
Were you injured in a work related incident?	YES NO

Please list all current medications : _____
_____
Please list all surgeries/ dates: _____
_____
Please check diagnostic tests performed: [ ] X-ray [ ] MRI [ ] CT Scan [ ] Bone scan
[ ] Bone Density [ ] EMG [ ] Ultrasound
Please describe your chief complaint and current condition: _____
_____

I believe all information to be true and complete: Signature _____ Date _____