HRC
HOME REHAB CONSULTANTS

MEDICAL HISTORY

Name ______ Ph ______
Emergency Contact ______ Ph ______

Present Condition/Previous Care

1. Have you had any previous physical therapy or other treatments this year such as chiropractic, acupuncture, etc? If yes, explain

2. Please list any prescription or non-prescription medication that you currently take

3. Please describe the problem(s) for which you seek physical therapy

Diagnostic tests

Check if you have had:

1. ☐ X-rays
2. ☐ MRI
3. ☐ CT Scan
4. ☐ EMG
5. ☐ Stress Test
6. ☐ Blood Test
7. ☐ Doppler Ultrasound
8. ☐ Biopsy

Describe your general health

1. ☐ Excellent
2. ☐ Good
3. ☐ Fair
4. ☐ Poor

Medical/Surgical History

Please check if you have ever had any listed

1. ☐ Arthritis
2. ☐ High blood sugar
3. ☐ Infectious disease
4. ☐ Circulation/vascular problems
5. ☐ Heart Problems
6. ☐ Parkinson's
7. ☐ Developmental problems
8. ☐ Diabetes
9. ☐ Cancer
10. ☐ Blood disorder
11. ☐ Muscular Dystrophy
12. ☐ Depression
13. ☐ Thyroid problem
14. ☐ Osteoporosis
15. ☐ Head injury
16. ☐ Multiple Sclerosis
17. ☐ Skin diseases
18. ☐ Lung problems
19. ☐ Stroke
20. ☐ Broken bones/Fractures
21. ☐ Low blood sugar
22. ☐ Kidney problems
23. ☐ Ulcers/Stomach problems
24. ☐ High blood pressure
25. ☐ Seizures/Epilepsy
26. ☐ Allergies
27. ☐ Other ______

Within the past year, have you had any of the following symptoms? (Check all that apply)

1. ☐ Chest pain
2. ☐ Joint pain/Swelling
3. ☐ Fever/Chills/Sweats
4. ☐ Dizziness/Blackouts
5. ☐ Nausea/Vomiting
6. ☐ Difficulty swallowing
7. ☐ Difficulty walking
8. ☐ Urinary problems
9. ☐ Shortness of breath
10. ☐ Loss of Appetite
11. ☐ Vision problems
12. ☐ Loss of balance
13. ☐ Weight loss/gain
14. ☐ Cough/hoarseness
15. ☐ Difficulty sleeping
16. ☐ Hearing problems
17. ☐ Weakness in arms/legs
18. ☐ Bowel problems
19. ☐ Heart palpitations
20. ☐ Pain at night
21. ☐ Headaches
22. ☐ Coordination problems
23. ☐ Other ______

By signing below, you state that all of the information is true and current to date.

Patient's Signature ______ Date ______
Spouse/Guardian Signature (if patient unable) ______ Date ______