Outpatient Medical History Information

Date: ________________________

Name: ____
Last First Middle Initial

Primary Physician: __________________________ **Referring Physician:** ______________________

Hospitalizations: (include surgeries, fractures or any other pertinent medical information) __________

Allergies: (specify) ______________________________

Current Medications: (include anti-inflammatory, pain and muscle relaxants) ______________

Have you or will you be receiving any of the following tests as the result of this injury?
(Please circle all that apply) X-Ray EMG CT Scan Doppler-Study MRI Other: ________

Results of Test(s): ______________________________

Wear Glasses/Contacts: (circle one) YES NO

Have you fallen in the past year? (circle one) YES NO **If YES, how many times?** _________

If YES to falling, did you sustain an injury as a result of the fall? (circle one) YES NO

Do you currently have any "Flu type" symptoms? (i.e. fever, coughing) (circle one) YES NO

If yes, what are symptoms: ______________________________

Do you have any open cuts, lesions, or wounds? YES NO **If YES, where:** ___________________

Personal History: (Current "C" or Past "P" please specify)

_______ High Blood Pressure
_______ Low Blood Pressure
_______ Angina
_______ Pacemaker
_______ Poor circulation
_______ Phlebitis
_______ Stroke
_______ Rheumatic Fever
_______ Diabetes
_______ Frequent Fainting
_______ Frequent Depression
_______ Frequent Swelling
_______ Tuberculosis

_______ Cancer/Tumor
_______ Arthritis
_______ Broken Bones
_______ Thin Bones
_______ Head Injury
_______ Metal Implants
_______ Seizures/Convulsions
_______ Frequent Diarrhea
_______ Frequent Nausea
_______ Poor Eyesight
_______ Poor Hearing
_______ Frequent Light - Headedness
_______ Kidney Problems

Blood Pressure: ______________
Pulse: ______________
Date of Next Doctor Visit: ______________

For Women Only:
Possibility of Pregnancy? YES NO

_______ Hepatitis
_______ Paralysis
_______ Lung Problems
_______ Heart Attack
_______ Other Cardiac Issues
_______ Other Health concerns
(please list below)

1) Chief complaint which brings you to ARC Physical Therapy +? ______________________

2) Please give goal of rehabilitation treatment. (Outcome of Therapy) ______________________

3) Work Status: (as a result of this injury) Full time Full time with restrictions Part time
Part time with restrictions Off work Other: ______________

4) Is this visit the result of an injury/accident? YES NO
If so, please explain how and where the injury occurred: ______________________

5) Was this injury work related? Yes No Date of injury/accident: ______________

6) What are the top (2) tasks you are unable to perform as a result of this injury? (be specific) or NA

1. ______________________________

2. ______________________________