ARC | Physical Therapy+™

Medical History Form

Patient Name: _____ **Date**: _____
Referring Physician: _____ **Primary Care Physician**: _____
Hospitalizations (Recent/Major Injuries/Surgeries): _____

_____

Allergies: _____
Are you allergic to LATEX: YES NO **Are you allergic to Dexamethasone**: YES NO
Current Medications (Prescribed and Over the Counter): _____

_____

Have you, or will you, be receiving any of the following tests as a result of your current injury:
X-Ray EMG CT Scan Doppler Study MRI Other: _____
Results of Test(s): _____
Do you wear Contacts or Glasses: YES NO
Have you fallen in the last year?: YES NO **If YES, how many times**: _____
If YES to falling, did you sustain any injuries: YES NO
Do you currently have any "flu type" symptoms (ie. fever, cough): YES NO
If YES, what are the symptoms: _____
Do you have any open cuts, lesions or wounds: YES NO **If YES, where**: _____
Do you use tobacco: YES NO **If YES, how much**: _____
Do you current have or have a history of any of the following? (Please mark all that apply)

- □ Anemia
- □ Angina
- □ Arthritis
- □ Cancer
- □ Cardiovascular Problems
- □ Holter Monitor – currently wearing?
  - □ Pacemaker
- □ Osteoporosis
- □ Thyroid Problems
- □ Pregnant or possibility of pregnancy
- □ Tuberculosis
- □ Head Injury
- □ Diabetes
  - □ Controlled
  - □ Uncontrolled
- □ Depression
- □ Dizzieness/Fainting
- □ Kidney Problems
- □ Asthma/COPD/Other
- □ Blood Thinners
- □ Poor Hearing
- □ Metal Implants
- □ High/Low Blood Pressure
  - □ Controlled
  - □ Uncontrolled
- □ Fractures/Broken Bones
- □ Headaches
- □ Hepatitis/HIV/AIDS
- □ MRSA
- □ Seizures
- □ Frequent Swelling
- □ Frequent Diarrhea/Nausea
- □ Paralysis

Reason for attending Therapy: _____
What tasks/activities do you find you have most difficulty with: _____

_____

What are your personal goals/outcomes you wish to see from treatment: _____

_____

Was this injury work related: YES NO **If yes, Date of injury**: _____
Was this injury a result of an accident (auto or 3rd party): YES NO **If yes please explain**: _

_____

Work Status: Full Time Part Time Off Work **Do you have restrictions**: YES NO

Signature of Patient: _____