BLAKE Physical Therapy

Specializing in Orthopaedic and Sports Injuries

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MEDICAL HISTORY

Name: _____ Date: _____

Have you RECENTLY experienced any of the following symptoms? (Check all that apply)

- ☐ Changes in bowel or bladder function
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance while walking
- ☐ Numbness/tingling
- ☐ Weight loss/gain
- ☐ Shortness of breath
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Chest pain/palpitations
- ☐ Fever/chills/sweats
- ☐ Pain at night
- ☐ Weakness/fatigue
- ☐ Difficulty swallowing
- ☐ Swelling in hands & feet

Have you EVER been diagnosed with any of the following conditions? (Check all that apply)

- ☐ Cancer (type) _____
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Pacemaker inserted
- ☐ Osteoporosis
- ☐ Chemical dependency (i.e., alcoholism)
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Depression
- ☐ Anemia
- ☐ Lung problems
- ☐ Thyroid problems
- ☐ Other_____
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Kidney/liver problems
- ☐ Stomach ulcers
- ☐ Epilepsy
- ☐ Parkinson's disease

Please list your current medications: _____

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? ☐ YES ☐ NO

ALLERGIES: _____

Are you latex sensitive? ☐ Yes ☐ No

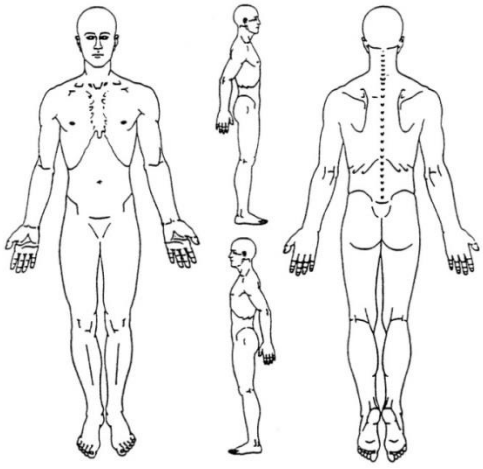
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

Body Chart:
Please mark the location of your pain and type on chart.

KEY:
X Sharp stabbing pain
O Dull achy pain
…. Numb/ Tingling
/// Throbbing
=== Burning



Rate your pain from "0" (No pain) to "10" (Worst Pain Imaginable)

Pain at the **LOWEST** level in the past 24 hrs: _____

Pain Currently: _____

Pain at the **HIGHEST** level in the past 24 hrs: _____

What is your goal for therapy at this time? _____

_____

_____

Patient Signature: _____ Date: _____