BioSport Physical Therapy
MEDICAL HISTORY

Patient Name: _____ Injury Date: _____
Leisure activities, including exercise routines:_____
_____
Occupation, include positions that comprise your workday: _____
_____
_____
Age: ___ Height: ___Weight: ___ BMI:18<25<30 Glucose Level:F70-99 80-130 HR: ___ BP: 200/110mmBR:12-20 O2: 88-90
Are you on a work restriction from your doctor? **Yes No** Are you latex sensitive? **Yes No**
Do you smoke? **Yes No** # of packs_____ Do you have a pacemaker? Yes **No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? **Yes No**

Have you recently noted (check all that apply)?

☐ Weight loss / gain	☐ Nausea / Vomiting	☐ Fatigue
☐ Muscle Weakness	☐ Fever / Chills / Sweats	☐ Numbness/Tingling
☐ Difficulty with balance while walking	☐ Falls (How many per month ____)	☐ Difficulty Swallowing
☐ Dizziness / lightheadedness	☐ Heartburn / Indigestion	☐ Constipation
☐ Change in bowel or bladder function	☐ Cough	☐ Headaches
☐ Fainting	☐ Shortness of Breath	☐ Diarrhea

Have you ever been diagnosed as having any of the following (check all that apply)?

☐ Liver Problems	☐ Pancreas	☐ Autoimmune Disorder	☐ Hernia
☐ Kidney Problems	☐ Spleen	☐ Anemia	☐ Asthma
☐ Gall Bladder	☐ Stomach	☐ Breathing Problems	☐ Epilepsy, seizures
☐ Appendix	☐ Multiple sclerosis☐	Thyroid Problems	☐ Metal Implant
☐ Heart Murmur	☐ Ulcers	☐ Lung disease	☐ Allergies
☐ High/Low Blood Pressure	☐ Stroke	☐ Diabetes	☐ Pneumonia
☐ Chest Pain/Angina	☐ High Cholesterol ☐	Other arthritic conditions	☐ Allergies to hot
☐ Blood clots	☐ Rheumatoid arthritis	☐ Incontinence	☐ MRSA
☐ Circulation Problems	☐ Surgeries	☐ Tuberculosis	☐ Osteoporosis
☐ Heart Disease	☐ Hepatitis	☐ Depressions	☐ Sexually Transmitted
☐ Heart Attack	☐ HIV /Aids	☐ Bladder/Urinary Infection	☐ Arthritis
☐ Emphysema/Bronchitis	☐ Parkinson	☐ Gout	☐ Joint Replacement
☐ Chemical dependency	☐ Cancer Type_____	☐ Nervous Disorder	☐ Fibromyalgia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

☐ Cancer	☐ High blood pressure	☐ diabetes	☐ Tuberculosis
☐ Heart Problems	☐ Stroke	☐ Thyroid Problems	☐ Depression
☐ Depression	☐ Blood Clots		

Explain & give approximate dates for any items indicated above: _____
_____

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**
ALLERGIES: List any medication(s) you are allergic to: _____
Are you currently taking Medications? ☐ Yes / ☐ No. (☐ check box if medication list was provided)

Medication	Reason	Dosage	Frequency	How Long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

BioSport Physical Therapy

Your Injury

What date (roughly) did your present symptoms start? Date:_____

What do you think caused your symptoms?

❑ lifting ❑ MVA ❑ A Fall ❑ overuse ❑ sports

❑ degenerative process ❑ impact injury ❑ at work ❑ unknown

Explain: _____

_____

_____

Have you ever had this problem before? ❑ Yes ❑ No Date:_____

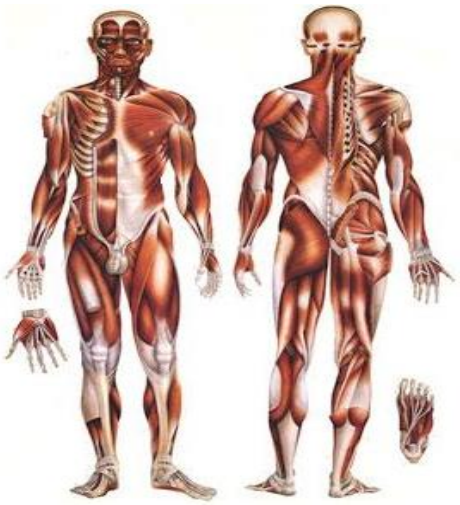
How long did it take for you to feel better before? _____

Please mark on the body where your symptom are located.

USE SYMBOLS:

Sharp Burning Aching Throbbing

Numbness **Pins & Needles**



Type of pain:

Sharp / Burning / Aching / pins & needles / numbness / throbbing

Other:_____

_____

_____

Does pain radiate (travel) into □ arms or □ legs? □ **Yes** / □ **No**

Rate your (average) pain on a 0-10 scale (0=no pain 10=severe).

Current _____ Best in 24hrs_____ Worse in 24hrs _____

Symptoms:❑Come & go ❑Are Constant ❑Constant but change with activity

How are you currently able to sleep at night due to your symptoms?

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain

❑ Sleep only with medication

When are your symptoms worst?

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best?

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

My symptoms are currently?

❑ Getting Better ❑ Getting Worse ❑ Staying about the same

List surgeries/conditions for which you have been hospitalized, including dates:

1. _____ 2._____3._____

Treatment received so far for this problem?

❑ Physical Therapy ❑ Chiropractic ❑ Pain Management Doctor ❑ Epidural ❑ Acupuncture ❑ Massage ❑Self Treatment

Please list special tests performed for this problem Date:_____ Imaging Center _____

❑ x-ray ❑ MRI ❑ Ultrasound ❑ nerve conduction ❑ labs

What Aggravates your symptoms:

□ sitting	□ lying down	□ walking	□ up/downstairs	□ reaching overhead
□ reaching in front	□ reaching behind	□ talking/chewing/yawn	□ repetitive activities	□ household activities
□ standing	□ squatting	□ sleeping	□ coughing/sneezing	□ looking up overhead
□ swallowing	□ stress	□ sustained bending	□ lifting	□ kneeling
□ carrying	□ running	□ throwing	□ crawling	□ work

What Relieves your symptoms:

□ sitting	□ lying down	□ walking	□ massage	□ medication
□ heat/cold	□ standing	□ stretching	□ rest	□ exercise

Identify at least 3 important activities that you are unable to do or are having difficulties with as a result of your problem/ symptoms. Rate your difficulty based on a 0 to 10 scale with 0 = "UNABLE TO PERFORM" and 10 = " NO DIFFICULTY "

1._____ 0 1 2 3 4 5 6 7 8 9 10

2._____ 0 1 2 3 4 5 6 7 8 9 10

3._____ 0 1 2 3 4 5 6 7 8 9 10

What do you feel your treatment for this condition should be: _____

_____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____