

Confidential Medical History/Evaluation

Zionsville Physical Therapy

Name _____ Referring MD: _____

Address _____ Birth Date: ___/___/___ Soc. Sec. # _____

Email address _____

Primary card holders name: _____ Address _____ Soc. Sec. # _____

Occupation: _____ Is this injury: Work related _____ Auto Accident _____

Chief Complaint: _____ Date of injury: ___/___/___

Current Symptoms: Pain Numbness Stiffness Weakness New Acute Chronic

List all medications you are currently taking: _____

Are you allergic to any medications: _____

List any surgeries: _____

Have you had any diagnostic or rehabilitative services for this injury? MRI X-rays Other _____

	<u>Yes</u>	<u>NO</u>	<u>Pain when performing</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Unable</u>
Asthma, Bronchitis or Emphysema	_____	_____	Bending	_____	_____	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Carrying groceries	_____	_____	_____	_____
Coronary Heart Disease	_____	_____	Changing positions	_____	_____	_____	_____
Do you have a Pacemaker	_____	_____	Sit to Stand	_____	_____	_____	_____
High Blood Pressure	_____	_____	Ascending Stairs	_____	_____	_____	_____
Heart Attack/Surgery	_____	_____	Descending Stairs	_____	_____	_____	_____
Stroke/TIA	_____	_____	Kneeling	_____	_____	_____	_____
Blood Clot/Emboli	_____	_____	Extended computer use	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	Eating	_____	_____	_____	_____
Thyroid trouble/Goiter	_____	_____	Household chores	_____	_____	_____	_____
Anemia	_____	_____	Driving	_____	_____	_____	_____
Infectious Disease	_____	_____	Lifting children	_____	_____	_____	_____
Diabetes	_____	_____	Lifting objects	_____	_____	_____	_____
Cancer or Chemo/Radiation	_____	_____	Pet care	_____	_____	_____	_____
Arthritis/Swollen Joints	_____	_____	Reading (concentration)	_____	_____	_____	_____
Osteoporosis	_____	_____	Self care- bathing	_____	_____	_____	_____
Varicose Veins	_____	_____	Self care – Dressing	_____	_____	_____	_____
Gout	_____	_____	Self Care – Shaving	_____	_____	_____	_____
Sleeping Difficulties	_____	_____	Sleep	_____	_____	_____	_____
Emotional/Psychological Problems	_____	_____	Sexual activities	_____	_____	_____	_____
Sudden Weight loss or gain	_____	_____	Sitting (prolonged)	_____	_____	_____	_____
Bowel Problems	_____	_____	Standing (prolonged)	_____	_____	_____	_____
Bladder Problems	_____	_____	Walking	_____	_____	_____	_____
Severe/Frequent Headaches	_____	_____	Yard Work	_____	_____	_____	_____
Vision/Hearing Difficulties	_____	_____	Sports	_____	_____	_____	_____
Dizziness or Faintness	_____	_____	Recreational activities	_____	_____	_____	_____
Are you pregnant	_____	_____	Exercise _____	_____	_____	_____	_____
Smoking	_____	_____	Are you aware of your diagnosis	Yes _____ No _____	_____	_____	_____
Alcohol consumption	_____	_____	Are you aware of your prognosis	Yes _____ No _____	_____	_____	_____

Signature: _____ Date / /

Parent/Guardian Signature: _____ Date / /