SOL PHYSICAL THERAPY

Patient Medical History

Last Name: ____________________ **First Name:** ______________________ **MI:**_____**DOB:**______________

Height: ____ ft _____ in **Weight:** _______lbs **Sex:** ◯ Male ◯ Female ◯ Prefer not to say

Describe your overall health: ◯ Excellent ◯ Very Good ◯ Fair ◯ Poor

Have you had any falls in the past 12 months? ◯ Yes ◯ No

If yes, when, and how frequently? ____

Personal Medical History:

	Yes	No
Asthma	◯	◯
Autoimmune Disorders	◯	◯
Cancer	◯	◯
Diabetes	◯	◯
Heart Trouble	◯	◯
Hepatitis A / B / C (specify)	◯	◯
High Blood Pressure	◯	◯
History of Substance Abuse	◯	◯

	Yes	No
HIV / AIDS	◯	◯
Latex Allergy	◯	◯
Low Blood Pressure	◯	◯
Neurological Disorder	◯	◯
Osteoarthritis	◯	◯
Osteoporosis	◯	◯
Pacemaker	◯	◯
Rheumatoid Arthritis	◯	◯

	Yes	No
Seizures	◯	◯
Smoker	◯	◯
Stroke	◯	◯
Thyroid Disorder	◯	◯
TMJ Disorder	◯	◯
Vascular Disorders	◯	◯
Are you pregnant?	◯	◯
Other:	◯	◯

Are you currently experiencing any of the following:

	Yes	No
Bruise Easily	◯	◯
Constipation	◯	◯
Fainting Spells	◯	◯
Incontinence	◯	◯

	Yes	No
Low Blood Pressure	◯	◯
Memory Problems	◯	◯
Pain or Tightness in Chest	◯	◯
Shortness of Breath	◯	◯

If Yes to any of the above, please explain: ____

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PHYSICAL THERAPY

Surgical History: ☐ See attached surgery list (Please ask front office for additional page if needed)

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____

Current Medications & Supplements: ☐ See attached medication list (Please ask front office for additional page if needed)

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Reason for Seeking Therapy

What part of your body will we be treating? ______________________________

Date of injury or onset of symptoms: ______________

Have you had surgery? ○ Yes ○ No **Date of surgery:** ______________

Describe how injury occurred (If applicable) : ______________________________

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____

Diagnostic tests completed: ☐ MRI ☐ CT Scan ☐ X-Ray ☐ Other: ______________

Have you seen any other provider within the last 30 days for this condition (i.e. massage therapist, chiropractic, athletic trainer, or acupuncturist)? ○ Yes ○ No **If yes, by whom?** ______________

Pain Scale: no pain = 0, worst pain ever = 10 **Current (0-10):** ________ **At its worst (0-10):** ________