MEDICAL HISTORY FORM

The below information is confidential. Your answers will help us determine if physical therapy can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as accurate and specific as possible. I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that all examinations and treatments are to be paid for as they are received. I hereby authorize the licensed physical therapist at VIP Therapy, LLC to examine and treat my condition as she deems appropriate through the use of Physical Therapy and I give authority for these procedures to be performed.

Signature of Patient *(or spouse/guardian)* _____ Date:_____

PLEASE FILL OUT THIS FORM AND BRING TO YOUR EVALUATION WITH YOU.

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PATIENT INFORMATION:

Patient Name:_____ Date:_____

Address:_____ City/State:_____ Zip: _____

Occupation: _____

Phone *(Preferred)*: _____ PHONE *(Work)*: _____

Do you choose to receive text messages regarding your care: □ Y □ N Age: _____

Marital Status: _____ Gender: □ F □ M DOB:_____

Referring Doctor:_____ Phone:_____ Fax:_____

Address:_____ City/State:_____ Zip: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____ City/State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Name of person responsible for payment of professional services: _____

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CURRENT HEALTH REPORT

Please describe the primary health complaint that you're seeking physical therapy care for, as well as date of onset of these symptoms:

What are your therapy goals? (What do you want to get our ot your therapy visits?)

How long has it been since you've felt really good for a week at a time?

Are your present complaints due to an injury? □ Y □ N Due to an auto accident? □ Y □ N

Is your condition getting □ Worse □ Better □ Staying the Same

What is your condition interfering with?

□ Walking □ Sitting □ Standing
□ Lifting □ Bending □ Sleeping
□ Other

What makes your symptoms better?

What makes your symptoms worse?

Current prescription medications and vitamins/supplements:

Do you have allergies/sensitivities? □ Y □ N List: _____

Have you had physical therapy in the past? □ Y □ N Type: _____

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HABITS OF DAILY LIVING:

Do you exercise? □ Daily □ Every other day □ Weekly □ None

Type(s) of exercise:

What types of work activities do you do? □ Sitting □ Standing □ Lifting □ Other

What is your stress level? □ Low □ Medium □ High Do you smoke? □ Y □ N

How many hours do you sleep at night? Does pain often wake you? □ Y □ N

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GENERAL HEALTH HISTORY:

List any major accidents, injuries or falls you have sustained:

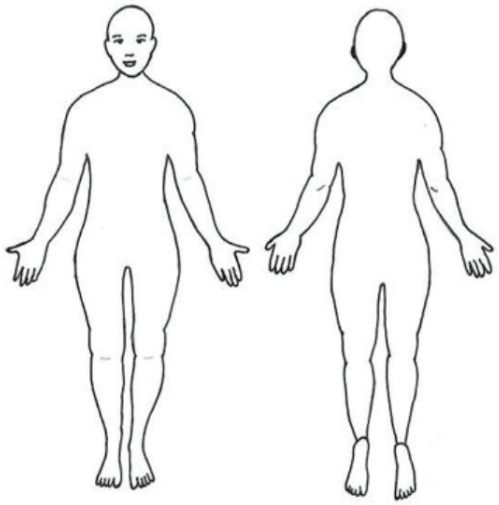
Have you broken any bones? □ Y □ N
If so, which bones? When did it happen?

Please list all past surgeries and approximate dates of service:

Have you had any x-rays or special imaging done in the last year? □ Y □ N

If so, when and what type? Which hospital?

Please use the image below to show me where you are experiencing your pain:



Rate that pain from 0 (no pain) to 10 (emergency room pain)

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SYSTEMS REVIEW

Do you now have or have you ever had any of the following conditions?

- □ Asthma, Bronchitis or Emphysema
- □ Shortness of Breath/Chest Pain
- □ Heart Disease/Angina
- □ High Blood Pressure
- □ Blood Clot
- □ Osteoporosis
- □ Vision Problems
- □ Thyroid/Goiter Problems
- □ Weight Gain
- □ Joint Replacement
- □ Cancer
- □ Arthritis
- □ Pacemaker
- □ Gout
- □ Anemia
- □ Osteopenia
- □ Hearing Issues
- □ Dizziness/Fainting
- □ Metal in Body/Surgical Implants
- □ Bowel/Bladder Problems
- □ Diabetes
- □ Stroke/TIA
- □ Heart Attack
- □ Infectious Disease
- □ Allergies
- □ Hernia
- □ Weakness
- □ Weight Loss

Please explain:

Are you aware of your current diagnosis? □ Y □ N

Are you currently pregnant? □ Y □ N Estimated Date of Delivery: _____

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____