MEDICAL HISTORY FORM
The Sharp End Physical Therapy LLC

Patient name:_____ Todays date:_____
Referring Physician's Name:_____ Date of injury/ onset_____
Primary Care Physician's Name _____ Are you currently working? Y___ N___
Cause of Injury or onset: _____ Date of next MD apt_____

Do you currently have any flu-like symptoms? Y____N____
Do you have any open cuts, lesions or wounds? Y____N____ If yes, where_____

What is your reason for seeking Physical Therapy_____
Because of this problem, what activities are you having difficulty with?

_____

_____

What are your personal goals/ outcomes you hope to achieve through Physical Therapy?

_____

_____

Describe your general health: EXCELLENT GOOD FAIR POOR

Do you wear glasses/ contacts? Y____N____ Need larger print? Y____N____

Have you been hospitalized or had a surgery in the past three months? Y____N____

Procedure performed, When?_____

Have you had previous Physical Therapy for this condition? Y____N____
__
What was done? What were the results? _____

How long were you treated? _____

Current Medications_____

Allergies: Medication_____Reaction_____

Are you allergic to LATEX? Y___N___ If Yes, what is the reaction_____

Are you allergic to Dexamethasone? Y___N___ Allergic to any metals Y___ N___

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

□ respiratory problems	□ anemia	□ asthma	□ COPD	□ headaches
□ Cardiovascular problems	□ pacemaker	□ seizures	□ CVA	□ depression
□ hypertension	□ hypotension	□ kidney disease	□ Diabetes	□ cancer
□ osteoporosis/osteopenia	□ dizziness/ fainting	□ fractures	□thyroid problems	□ arthritis
□ blood thinners/anticoagulant	□ currently pregnant	□ MRSA	□ hepatitis/ HIV	

Other_____

Signature of Patient_____ Reviewed by Therapist_____ Date_____