Bodies In Motion Physical Therapy, Inc.
Medical History Information

Name: _____ Date of Birth/Age_____//_____ Height: ____ Weight: ____
If you are **65 years or older**, have you had 2 or more falls in the past year or had a fall resulting in injury? **Yes / No**
Occupation:_____ Current activities/exercise program: _____

Primary and/or Referring Physician_____ How did you hear about us? Internet | MD | Friend:_____

1. Please check if you currently have any of the following problems/conditions:

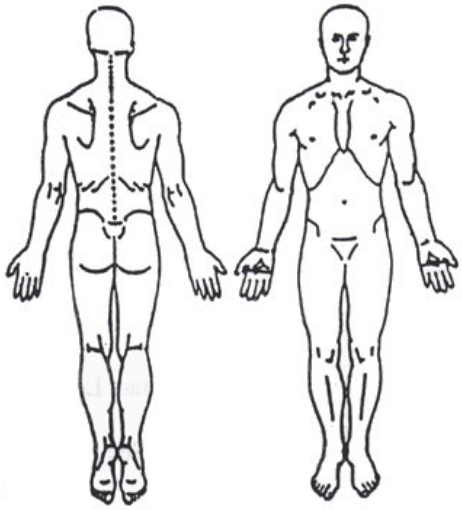
□ Diabetes	□ Hepatitis / Liver Dysfunction	□ Arthritis or joint problem
□ High Blood Pressure	□ Stomach Ulcers	□ Immune system disorder
□ Heart Disease	□ Nausea and/or vomiting	□ Unusual fatigue or weakness
□ Heart Attack (Date_____)	□ Indigestion, heartburn, reflux	□ Asthma
□ Stroke (Date_____)	□ Change in ability to urinate	□ Tuberculosis
□ Pacemaker	□ Difficulty w/bowel movements	□ Productive Cough
□ Seizures	□ Kidney or bladder infections	□ Night sweats
□ Head trauma	□ Prostate problems	□ Chills & fever
□ Fainting / Loss of Consciousness	□ Difficulty swallowing	□ Unexplained weight loss
□ Dizziness	□ Chronic Inflammation	□ Bleeding disorders
□ Loss of Balance/ balance deficits	□ Pregnancy (Due Date_____)	□ Bruises easily
□ Clumsy walking pattern	□ Post partum or nursing	□ Use of blood thinners
□ Visual disturbances	□ Incontinence	□ Use of steroids/prednisone
□ Headaches	□ Thyroid Dysfunction	□ Drink Caffeine(#/day_____)
□ Emphysema / COPD	□ Depression / mental Illness	□ Drink alcohol (#/wk_____)
□ Cancer _____	□ Other _____	□ Smoke (packs/day_____)

2. Have you had any of the following tests: __ X-Ray __ MRI __CT Scan __ Lab Work __ EMG

What were you the findings for the above?

3. Please list any surgeries including the dates: _____

4. What are you here for today (primary complaint)? Please mark on chart →
_____



5. Rate your pain (1=minimal 10=severe): At its **worst** _____ At its **best:** _____
6. Date of Injury (if applicable): _____
7. Have you had this problem or these symptoms in the past? **Yes / No**
   If yes, when and what helped relieve and aggravate the symptoms?
   _____
   If yes, how often do you have the symptoms?
   _____
8. Are the episodes increasing in frequency? **Yes / No**
9. Are the episodes increasing in severity? **Yes / No**
10. Are the episodes changing in character? **Yes / No**
11. What is the longest amount of time you missed work or rec activities due to your symptoms? _____

12. List the goals you hope to achieve from Physical Therapy:

Signature_____ **Date**_____

Thank you for taking time to fill out this information sheet. Please feel free to ask questions pertaining to your condition during your examination and treatment.