

PREMIER

PHYSICAL THERAPY

Past Medical History

Please complete to assist us in your treatment/evaluation. Thank You.

Patient Name: _____
Date: _____ Age: _____ Sex: _____ Date of injury/onset of pain: _____
How did the injury occur/when did the pain start?

Do you have an attorney representing you as a result of this injury/pain?

___ No ___ Yes _____ Name of Attorney

List the current medications(including herbal supplements)that you are taking:

Past Surgeries(Date): _____

Is there a medical reason that you should not exercise? ___ Yes ___ No

If Yes please explain _____

Do you have a past history of:	Yes	No	When/How long?
Alcohol consumption	___	___	_____ amount per day Quit Date _____
Smoking	___	___	_____ amount per day Quit Date _____
Heart disease	___	___	_____
High blood pressure	___	___	_____
Diabetes	___	___	Type 1 _____ Type 2 _____
Depression	___	___	_____
Over the past 2 weeks have you felt down/hopeless?			_____ Yes ___ No
Over the past 2 weeks, have you felt little interest/pleasure in doing things?			_____ Yes ___ No
Seizures	___	___	_____
Angina	___	___	_____
Stroke	___	___	_____
Pregnant currently	___	___	_____
Liver Disease	___	___	_____
Breathing/Lung Problems	___	___	_____
Heart surgery	___	___	_____
Heart Palpitations	___	___	_____
Infectious blood disease	___	___	_____
Known Allergies	___	___	_____
Other	___	___	_____

What are your goals for rehabilitation? _____

Do you need a vocational counselor? _____ Yes _____ No

Patient Signature: _____ Date: _____