SEBASTOPOL PHYSICAL THERAPY AND PILATES STUDIO
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Medical History Form

Patient Name: ______________________________ **Date:** ____________________

***HEIGHT** ________________ ***WEIGHT** ______________ ***provider to calc *BMI** ________

***PAIN SCALE today (1-10) WITH 10= TO TRIP TO THE ER DEPT:** ____________________

Age: _______ **Dominant Hand:** Left / Right **Smoker?** □ **No** □ **Yes**

Allergies to latex or creams? □ Yes explain: ____

Have you ever been diagnosed as having any of the following conditions?

□ Cancer, Type:______________	□ Heart Problems:______________	□ High Blood Pressure
□ Diabetes, Type:____________	□ Chemical Dependency	□ Rheumatoid Arthritis
□ AIDS/HIV	□ Mental Illness	□ Tuberculosis
□ Stroke, Date:______________	□ Kidney Disease	□ Anemia
□ Epilepsy	□ Asthma	□ Emphysema/Bronchitis/COPD
□ Circulatory Problems	□ Thyroid Problems:____________	□ Auto Immune:__________
□ Depression	□ Hepatitis	□ Other Neuro Disorders:___
□ Fibromyalgia	□ Polio	□ Dementia/Alzheimer's
□ Pacemaker/Defibrillator	□ Osteoporosis/Osteopenia	□ Other:______________

Previous Surgeries and date(s): ____

____

Have you recently noted: (Check all that apply)

□ Weight loss or gain (>5% in 4 weeks)	□ Nausea and/or Vomiting	□ Fatigue
□ Weakness	□ Fever/Chills/Sweats	□ Numbness/Tingling

***Have you fallen within the past year?** □ **No** □ **Yes** **How many times?** __________________

***Did any of the falls result in an injury?** □ **No** □ **Yes:**

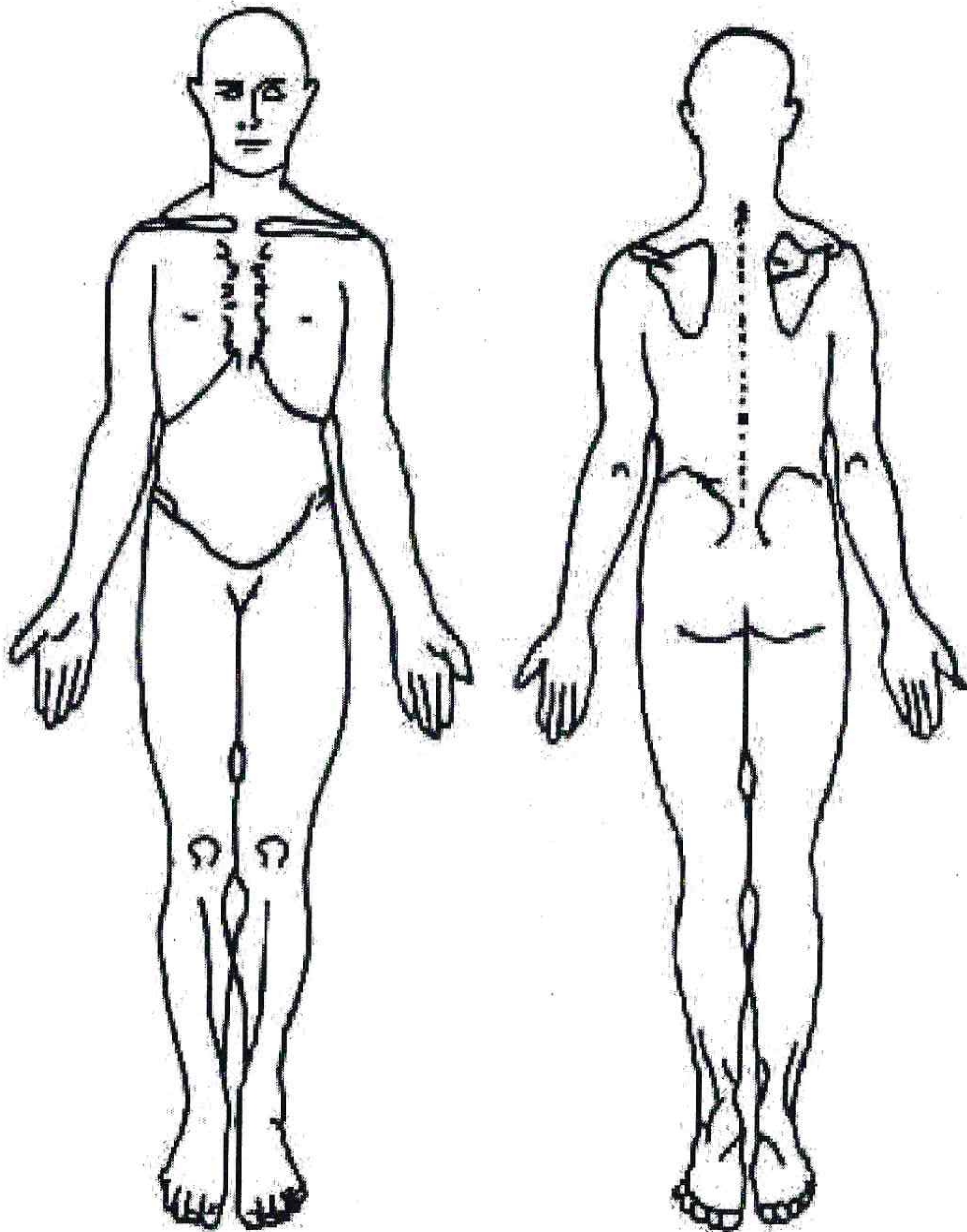
Employee use:

Standardized Test Used: __________ Score: __________ Blood Pressure __________

Risk assessment triggered >65 - 2 or more falls – or 1fall with an injury

***Medications:** Please include all prescriptions, over the counter drugs, vitamin and herbal supplements. You may provide us with your own print out or ask for additional sheet from our receptionist.

NAME	DOSAGE/FREQUENCY	REASON FOR TAKING	METHOD



What is your pain level on a 0 – 10 scale
(0 is no pain, 10 = emergency dept)

»At Rest ___

»With Activity ___
Mark on the chart where your problem areas and/or pain is.

What makes you feel better?

____

____

____

____

What makes you feel worse?

____

____

____

Your GOALS for Physical Therapy:

____