ProCare Therapy Services
Patient Medical History Form

Name _____ DOB _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

Medical History: (please check any condition you have a history of. Items not checked are understood to be negative.)

_____ High Blood Pressure	_____ Abnormal Bleeding	_____ Bowel or Bladder problem
_____ Heart problem	_____ Asthma	_____ Autoimmune disorder
_____ Abnormal heart rate	_____ Emphysema	_____ Recent or sudden weight loss/gain
_____ Pacemaker	_____ Chronic lung problem	_____ Thyroid problem (hyper or hypo)
_____ Heart palpitations	_____ Chronic heartburn	_____ Diabetes (medication dependent Y/N)
_____ Angina (chest pain)	_____ History of Ulcers	_____ Cancer/Tumors (where?
_____ Shortness of Breath	_____ High Cholesterol	_____ Seizures/Epilepsy
_____ Osteoporosis	_____ Night sweats	_____ Chronic heartburn/intestinal upset
_____ Arthritis	_____ Dizziness	_____ Hearing problems

Other: _____

Do you have history of fractures?	Yes	No	Where?	_____
Do you have a history of back/neck pain	Yes	No	When?	_____
Do you have any metal implants?	Yes	No	Where?	_____
Do you Smoke	Yes	No	How much/day?	_____
Do you exercise regularly?	Yes	No	How often?	_____
Do you have any known allergies	Yes	No	Please list	_____
Are you allergic to latex	Yes	No		
Are you pregnant or suspect pregnancy?	Yes	No		

Medications: Please check if you are taking any of the following (Please list names of medications)

_____ Blood Pressure Medication	_____
_____ Heart Medication	_____
_____ Anti-Coagulants (blood thinners)	_____
_____ Muscle Relaxants	_____
_____ Pain Killers	_____
_____ Diabetes Medication (ie: Insulin)	_____
_____ Steroids (cortisone)	_____
_____ Anti-Inflammatories	_____

Form: Patient Medical History Form Rev A
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_____ _____

_____ Other Medications _____

Surgeries: Please list all surgeries, including date:

_____

_____

_____

Diagnostic Tests: Please check test(s) for current problem only:

_____ X Rays _____ CT Scan _____ MRI _____ Bone Scan _____ EMG

_____ Blood Chemistry _____ Ultrasound _____ Bone Density _____ Other _____

Have you seen anyone else for your current problem?

_____ Orthopedic Surgeon _____ Physician/MD _____ Podiatrist _____ Chiropractor _____ Dentist

_____ Neurologist/Neurosurgeon _____ Osteopath/DO _____ Physical Therapist Date _____

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities?	Yes	No
Do you have any weakness in your arms or legs?	Yes	No
Do you have any coordination or balance problems?	Yes	No
Do you have difficulty walking?	Yes	No
Do you experience dizziness or vertigo with a change in position?	Yes	No
Have you experienced headaches as a result of your condition?	Yes	No

CHIEF COMPLAINT/CURRENT CONDITONS: Please describe:

_____

_____

_____

Please rate your pain in this scale of 0-10:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

I believe all information above to be true and complete:

Patient Signature _____ Date _____

Therapist Signature _____ Date _____

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