Cass Regional Medical Center

Physical and Occupational Therapy

Name: _____ **Date:** _____

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Do you have or have you ever been diagnosed with any of the following:

Arthritis	**Yes/No**	**Diabetes**	**Yes/No**	**Heart Condition**	**Yes/No**
Bladder Problems	**Yes/No**	**Dizziness/Fainting**	**Yes/No**	**Hepatitis**	**Yes/No**
Blood Clot/Emboli	**Yes/No**	**Energy Loss**	**Yes/No**	**High Blood Pressure**	**Yes/No**
Bowel Problems	**Yes/No**	**Epilepsy/Seizures**	**Yes/No**	**HIV/AIDS**	**Yes/No**
Cancer	**Yes/No**	**Gout**	**Yes/No**	**Numbness/Tingling**	**Yes/No**
Chest Pain	**Yes/No**	**Headaches**	**Yes/No**	**Osteoporosis**	**Yes/No**
Respiratory Problems	**Yes/No**	**Sleeping Problems**	**Yes/No**	**Stroke/TIA**	**Yes/No**
Thyroid Trouble	**Yes/No**	**Tuberculosis**	**Yes/No**	**Vision Problems**	**Yes/No**
Currently Pregnant	**Yes/No**	**Hearing Problems**	**Yes/No**	**Psychological Problems**	**Yes/No**
Weight loss/gain	**Yes/No**	**Other:**	**Yes/No**		

Please list any allergies you may have: _____

Are you allergic to latex? _____

Please list all medications you are currently taking (prescription and non-prescription): _____

_____

_____

At the present time, would you describe your overall health as: (circle one)

Excellent Good Average Below Average Poor

At the present time, whom do you live with? (circle all that apply)

Alone Spouse/significant other Child(ren) Relatives Group Setting

Do you have a safe home environment? Yes/No

Past Orthopedic Medical History: **Please indicate any previous orthopedic injuries or surgeries.**

Neck Injury/surgery	**Yes/No**	**If yes, please describe:**
Shoulder injury/surgery	**Yes/No**	**If yes, please describe:**
Elbow injury/surgery	**Yes/No**	**If yes, please describe:**
Hand injury/surgery	**Yes/No**	**If yes, please describe:**
Back injury/surgery	**Yes/No**	**If yes, please describe:**
Hip injury/surgery	**Yes/No**	**If yes, please describe:**
Knee injury/surgery	**Yes/No**	**If yes, please describe:**
Ankle/foot injury/surgery	**Yes/No**	**If yes, pleas describe:**

Have you had any falls in the past year? **Yes/No**

Tell us about the condition or injury which we are seeing you for:

When did your injury first occur? Or when did you first start to notice your symptoms? _____

_____

Where are your symptoms located? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Which, if any, MEDICAL PROFESSIONALS have you seen for this injury? (circle all that apply)
General Practitioner Orthopedist ER Physician Neurologist Podiatrist
Physical Therapist Occupational Therapist Massage Therapist Chiropractor

Which, if any medical test have you had for this injury? (circle all that apply) x-ray MRI CT scan
arthrogram myelogram EMG/nerve conduction Blood work

What is the main problem related to this condition? _____

_____

Have you received any injections for your current injury/condition? Yes/No Did it help? Yes/No

How often do you experience your current symptoms? Always Occasionally Seldom

Pain:

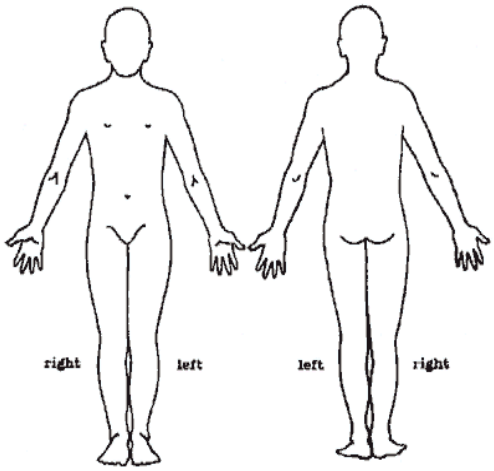
Using this scale (0=no pain, 10=emergency type pain)

I currently rate my pain at a: _____

My HIGHEST pain in the last 30 days has been: _____

My LOWEST pain in the last 30 days has been: _____

Please mark the location of your pain or other symptoms on the diagram below.



What do you hope to accomplish with therapy? _____

_____

Patient's Signature: _____ **Date:** _____

Therapist's signature: _____ **Date:** _____