WHMC Therapy Services

Medical History Form

Please complete the following questions to assist us in providing a thorough and complete evaluation, and developing an appropriate plan of care for you. If you do not understand a question, or have concerns, your therapist will assist you.

Name: _____ Age: _____ Birthdate: _____

Height: _____ Weight: _____

CHIEF COMPLAINT

Describe the problem(s) for which you seek therapy _____

_____

When did the problems begin (date of onset)? _____

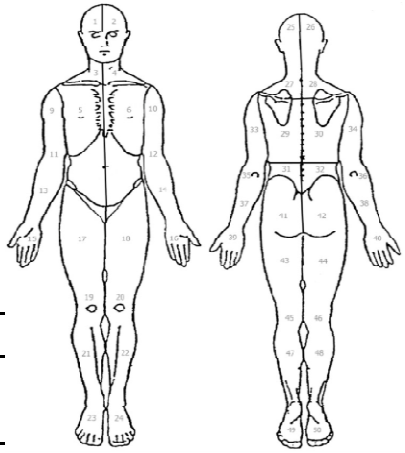
How did the problem start? _____

_____

Have you experienced this issue before? ◯ Yes ◯ No Date: _____

Do you have pain? ◯ Yes ◯ No ◯ Sometimes

On the body diagram, please indicate the area(s) where you feel pain:



Rate your pain on a 0-10 scale (0: no pain, 10: severe pain):

Current: _____ Best: _____ Worst: _____

What makes the problem(s) better?

_____

_____

What makes the problem(s) worse?

_____

_____

What actvities are you limited in doing because of your current problem? _____

_____

Have you had previous treatment(s) for this issue? ◯ Injection ◯ PT ◯ OT ◯ ST

◯ Other _____

Have you had any diagnostic tests for this issue? ◯ MRI ◯ X-Ray ◯ CT Scan

◯ Other _____

What were the results? _____

What are your goals for therapy? _____

_____

LIVING ENVIRONMENT

◯ Private home ◯ Private apartment ◯ Assisted living/skilled nursing
◯ Homeless ◯ Other _____

Do you live: ◯ Alone ◯ Parent ◯ Caregiver ◯ Other _____
◯ Spouse/significant other ◯ I am the caregiver of a person (child or adult)

Does your home have:
◯ Stairs (Circle one: no railing / railing, one side / railing, both sides)
◯ Ramps ◯ Elevator ◯ Other _____

Do you use:
◯ Cane ◯ Manual wheelchair ◯ Other _____
◯ Walker ◯ Power wheelchair

Do you drive? ◯ Yes ◯ No

EMPLOYMENT/WORK

◯ Full-time ◯ Disability ◯ Retired Occupation: _____
◯ Part-time ◯ Student ◯ Unemployed

SOCIAL/HEALTH HABITS

How do you rate your overall health? ◯ Excellent ◯ Good ◯ Poor
◯ Very Good ◯ Fair

What is your normal activity level? ◯ Sedentary ◯ Active
◯ Low activity ◯ High activity/Athletic

What activities do you participate in?

_____

Duration _____ (minutes) Frequency _____ x per day / week

Do you currently smoke tobacco or vape? ◯ Yes ◯ No # of packs per day _____
Have you smoked in the past? ◯ Yes ◯ No Year quit: _____
Do you currently use marijuana or other recreational drugs? ◯ Yes ◯ No Frequency _____

How many days per week do you drink beer, wine, or other alcoholic beverages, on average? _____
How many drinks do you have on an average day? _____

MEDICAL/SURGICAL HISTORY

Have you had any of the following symptoms? (Check all that apply)

- ◯ Abdominal pain
- ◯ Bowel problems
- ◯ Chest pain
- ◯ Cough (persistent)
- ◯ Coordination problems
- ◯ Difficulty sleeping
- ◯ Difficulty walking
- ◯ Difficulty swallowing/speaking
- ◯ Dizziness
- ◯ Fever/chills/sweats
- ◯ Feeling downhearted/blue
- ◯ Headaches
- ◯ Joint pains/swelling
- ◯ Nausea/vomiting
- ◯ Open wound(s)
- ◯ Shortness of breath
- ◯ Sensation changes
- ◯ Urinary problems/UTI
- ◯ Urinary/bowel incontinence
- ◯ Vision problems
- ◯ Weakness
- ◯ Weight loss/gain

Please check if you have ever been diagnosed with any of the following:

- ◯ Anxiety
- ◯ Aortic aneurysm
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation (A-fib)
- ◯ Bipolar
- ◯ Broken bones
- ◯ Cancer
- ◯ Congestive heart failure
- ◯ Circulation/vascular changes
- ◯ COPD
- ◯ Deep Vein Thrombosis
- ◯ Depression
- ◯ Diabetes
- ◯ Dementia
- ◯ Emphysema
- ◯ Fibromyalgia
- ◯ Gout
- ◯ Hearing loss
- ◯ Heart attack
- ◯ Heart disease
- ◯ High cholesterol
- ◯ High blood pressure
- ◯ Infectious disease
- ◯ Kidney disease
- ◯ Low blood sugar
- ◯ Lymphedema
- ◯ Neurological condition
- ◯ Osteoporosis
- ◯ Osteopenia
- ◯ Multiple Sclerosis
- ◯ Parkinson's
- ◯ Peripheral neuropathy
- ◯ Psychological/emotional problems
- ◯ Rheumatoid arthritis
- ◯ Seizures/epilepsy
- ◯ Skin diseases
- ◯ Stroke
- ◯ Thyroid problems
- ◯ Venous Insuffiency
- ◯ Other _____

Females: Are you pregnant? ◯ Yes ◯ No

BALANCE

Have you fallen in the past year? ◯ Yes ◯ No If yes, how many times? _____

OTHER MEDICAL EQUIPMENT

Do you have:

◯ Colostomy	◯ Hearing Aids	◯ Port
◯ Deep Brain Stimulator	◯ Insulin Pump	◯ Prosthesis
◯ Glasses/Contacts	◯ Pacemaker	◯ Other _____

Please describe any surgeries and indicate the dates (month and year), location, and surgeon

_____

_____

_____

Please list all medications you are currently taking, including over the counter medications, vitamins, supplements and herbal remedies. Please list dosage and frequency. (Attach list if necessary).

_____

_____

_____

Are you allergic to any medication(s)? ◯ Yes ◯ No

If yes, please list all medications and reactions.

_____

_____

Do you have any other health concerns or allergies not listed? ◯ Yes ◯ No

_____

_____

I, the undersigned, have read and understand the questions asked on this form. I also confirm that the above medical history provided on this form is true and complete to the best of my knowledge.

_____ _____

Patient signature (or legal guardian) Date