In-Motion
Physical Therapy Services
10557 New Church Road
Dallas, TX 75238

PATIENT MEDICAL HISTORY INFORMATION

Name _____ Date_____ Email Address_____

When did the current problem begin? (Date of onset) _____ Date of surgery _____

Cause of current problem / Mechanism of injury _____
_____

Occupation _____ Were you injured on the job? _____

Are you currently working? Yes No without restrictions with restrictions _____

Have you been treated for this problem before? Yes No
_____

Please list activities that you now have difficulty performing because of this problem
_____

Recent tests: (Please circle) X-ray MRI CT-Scan EMG EEG

Results _____ When do you return to your physician? _____

List all past major surgeries and hospitalizations (include dates)
_____
_____

Have you had or do you have any of the following? (Please circle)

Heart Disease	yes	no	Blood Clot	yes	no	Spine injury	yes	no
Congestive Heart Failure	yes	no	Seizure Disorder	yes	no	Knee injury	yes	no
Pulmonary disease	yes	no	Kidney disease	yes	no	Fracture	yes	no
High Blood Pressure	yes	no	MS	yes	no	If yes, where _____		
Cancer	yes	no	Parkinson's	yes	no	Ankle injury	yes	no
If so, what type? _____			Asthma	yes	no	Shoulder injury	yes	no
Active Infection	yes	no	Stroke	yes	no	Elbow injury	yes	no
Diabetes	yes	no	Pregnant now?	yes	no	Wrist injury	yes	no
If yes, what is your normal blood sugar level? _____						Head injury	yes	no
						Other: _____		

I have problems with learning because of: Sight Hearing Language Culture/Religion Mental Status No difficulties

Do you drive? Yes No Do you exercise? Yes No

Do you use any agency (i.e. Home Health) or people to help you with your care? Yes No
If yes, agency or person used: _____

Circle all that apply: Unintentional Weight Loss Overweight Nutritional risk Edema/Swelling

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List all medications

_____

_____

_____

Rate present pain (circle): 0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable pain

Have you had any falls within the last yr?

_____

_____

Is there any other information we should know about that would affect your treatment or response to therapy?

_____

_____

For Clinical Use Only

_____ _____
Therapist's Signature Date