OmniPoint Health
World-Class Care. Hometown Service.

Medical History Form

Please take the time to thoroughly complete this form. Your history is important for developing your treatment plan.

Name _____ Date of Birth _____

Physician/Provider Name _____ Phone # _____

Date of Injury _____ **Date of Surgery** _____ **Type of Accident** _____

What is your reason for coming to physical therapy? _____

Have you been treated for this condition prior to today? _____ YES _____ NO

If so, what type of treatment(s) have you received _____

Please list all medications you are currently taking: _____

_____

_____

If more space needed, please use back of this form.

Are you allergic to any medications? _____

Do you have a history of any of the following:

____ Bone/joint disorder	_____ Back pain	_____ Neck pain	_____ Shortness of Breath
____ High blood pressure	_____ Seizures	_____ Diabetes	_____ Asthma
____ Heart problems	_____ Dizziness	_____ Cancer	_____ Headaches
____ Bladder problems	_____ Arthritis	_____ Pacemaker	_____ Anemia
____ Bowel problems	_____ Stress/tension	_____ Depression	

Other _____

Females Only: Are you pregnant, planning a pregnancy, or nursing a child? _____ YES _____ NO

Please list recent hospitalization/surgeries: _____

_____

Are you currently working? _____ YES ____ NO

(If no, what is your last day worked? _____)

Occupation: _____

Hrs/day worked _____ Days/Week _____

What is your current activity level?

_____ Lying _____ Sitting _____ Standing

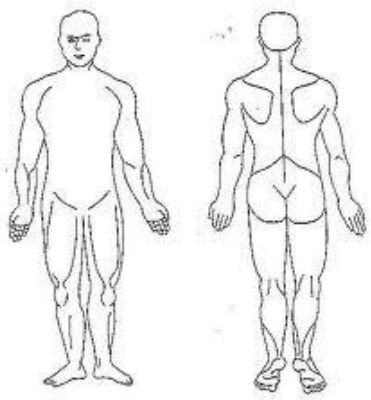
_____ Walking _____ Physical Labor

_____ Recreation/Exercise

Has your physician/provider put you on lifting restrictions?

____ YES ____ NO

Draw on diagram where you are experiencing pain



Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

In your best words, describe your pain/ailment: _____

Patient Signature _____ Date _____

Providers Initials _____ Date _____