KERRY BECHT
PHYSICAL THERAPY & THERAPEUTIC MASSAGE

MEDICAL HISTORY FORM

Patient name:	Date:
Main area of concern:	

Indicate how you sustained this condition:

- ☐ Work related injury
- ☐ Motor vehicle accident
- ☐ Athletic/Recreation injury
- ☐ Injury related to lifting
- ☐ Cause unknown
- ☐ Recurrence of prior condition
- ☐ Other: ____________________

Have you had surgery related to this condition? ☐ Yes ☐ No
If yes, what type of surgery?____Date of Surgery: ________________

Are you presently taking medication? ☐ Yes ☐ No
If yes, please list and specify amounts: ____
____

What specific activities are you having difficulties with? ____
What are your personal goals you hope to achieve from physical therapy? ______________________________________
____

Have you had any physical therapy, occupational therapy, or chiropractic care for this condition? ☐ Yes ☐ No
If yes, please explain ____

PLEASE CHECK IF YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ Diabetes
- ☐ Chest Pain/Angina
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Vascular Disease
- ☐ CVA/Stroke/TIA
- ☐ Seizures
- ☐ Skin Abnormalities
- ☐ Sexual Dysfunction
- ☐ Nausea/Vomiting
- ☐ COPD
- ☐ Thyroid Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Arthritis
- ☐ Hernia
- ☐ Recent Fractures
- ☐ Headaches
- ☐ Dizziness/Fainting
- ☐ Liver/Gallbladder Problems
- ☐ Kidney Problems
- ☐ Bowel/Bladder Problems
- ☐ Metal Implants
- ☐ Ringing in your Ears
- ☐ MRSA
- ☐ Special Dietary Guidelines
- ☐ HIV
- ☐ Hepatitis
- ☐ Asthma
- ☐ Depression
- ☐ Anxiety
- ☐ Allergies: ______________________
- ☐ Cancer: ________________________

Are you Pregnant? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No

If you answered "yes" to any of the above, please explain and give approximate dates: _________________________________
____

Please list any other surgeries and tests you have had, including type and date: _______________________________________
____

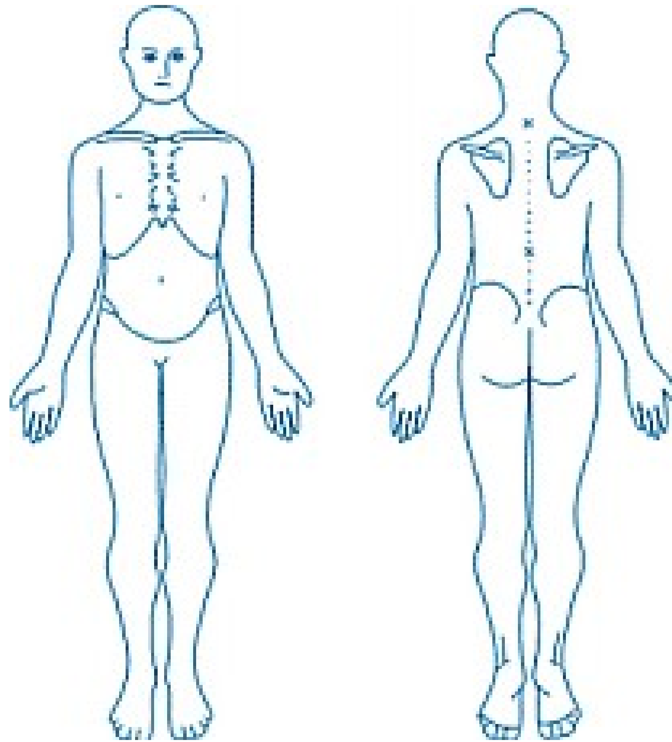
Do you participate in any sports, exercise programs, or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe: ____

Is there any other information regarding your past medical history that we should know about? ______________________
____

Patient/Guardian Signature____Date ____________________________

PAIN AND SYMPTOM CHART

Please indicate by shading in below where your symptoms are located:



Please circle the appropriate number that best describes your pain level:

0	No Pain
1	Mild Pain; you are aware of it, but it doesn't bother you
2	Moderate Pain that you can tolerate without medication
3	Moderate Pain that requires medication
4-5	More Severe Pain; you begin to reduce your activity level
6	Severe Pain
7-9	Intensely Severe Pain
10	Most Severe Pain; it may require a visit to the Emergency Room

Patient/Guardian Signature ____ Date ______________________

Therapist Signature ____ Date ______________________