

**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Injury/Onset: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Are you pregnant? Y / N Please list any test results (X-ray, MRI, tc): \_\_\_\_\_  
 Referring MD: \_\_\_\_\_ Phone: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_  
 \_\_\_\_\_  
 Other MD/phone (Please list *any* other MD who is prescribing or who you are receiving care from): \_\_\_\_\_

**Fall Risk Assessment:**

1. Have you fallen in the past year?  yes  no Describe: \_\_\_\_\_

2. Did you sustain an injury when you fell?  yes  no Describe: \_\_\_\_\_

**Do you have any past or present history of:**

Heart Disease, High Blood Pressure, Angina, Pacemaker?

Respiratory Problems, Asthma, Allergies, TB?

Diabetes (Any type)?

Arthritis( Diagnosed by M.D.)?

Bone Disease(s)

Skin Disorders, Eczema, Psoriasis, Athlete's foot?

Communicable Diseases, hepatitis, TB?

History of Cancer (Any type)?

Psychiatric history

Any metal or artificial implants?

Any previous injuries to the same area?

Any previous motor vehicle accidents with injuries?

Any previous surgeries?

Any history of neurological conditions? (seizure, stroke, etc)

Do you have any latex allergies?

Do you have any other medical conditions (please define below)

Do you have a Do Not Resuscitate (DNR) Order?

**Yes**

**No**

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Please explain any YES answers and state date of occurrence: \_\_\_\_\_

In the diagram on the right, please mark the area(s) where your pain is located using the following symbols:

**X = PAIN**

**/// = PINS AND NEEDLES**

**O = NUMBNESS**

**↓ = SHOOTING PAIN**

Please rate your pain right now on a scale of 0 – 10 with 0 being no pain at all and 10 being the worst pain imaginable:

**0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10**

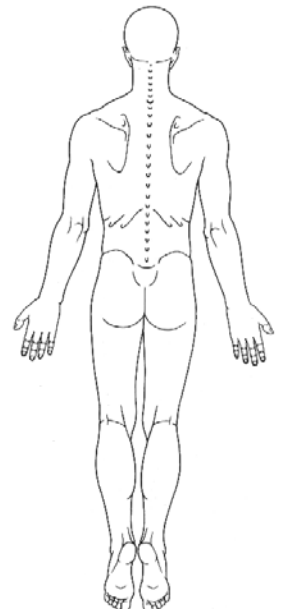
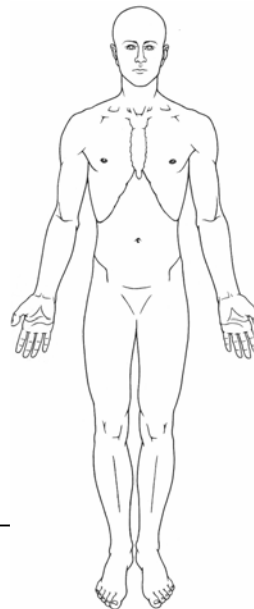
What would you rate your pain at its lowest? /10

What would you rate your pain at its highest? /10

**Please describe your pain (circle all that apply).**

constant intermittent sharp dull aching burning

tingling stabbing throbbing shooting cramping



**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_