Memorial Physical Therapy Center
4700 Memorial Drive Ste 150 Belleville, IL 62226
(618) 257-5250 / Fax #- (618) 257-6929

PATIENT HISTORY

Name: _____ Date: _____

Referring Physician: _____

Next appointment with your doctor: _____ Height: _____ Weight: _____

Please check yes/no for any of the following medical conditions:

Are you currently or possibly pregnant?	☐ Yes	☐ No	Seizures?	☐ Yes	☐ No
Do you have a pacemaker/defibrillator?	☐ Yes	☐ No	Do you wear glasses?	☐ Yes	☐ No
Do you have any implants ?	☐ Yes	☐ No	Do you use hearing aids?	☐ Yes	☐ No
Do you have a history of cancer?	☐ Yes	☐ No	Smoking or tobacco use?	☐ Yes	☐ No
Do you take blood pressure medicine?	☐ Yes	☐ No	Dizziness?	☐ Yes	☐ No
Do you have bowel/bladder problems?	☐ Yes	☐ No	Fainting problems?	☐ Yes	☐ No
Do you have diabetes"	☐ Yes	☐ No	Have you ever had a stroke?	☐ Yes	☐ No
Do you have heart problems?	☐ Yes	☐ No	Anxiety or other psychological problems?	☐ Yes	☐ No
Breathing problems, asthma?	☐ Yes	☐ No	Do you have any tattoos?	☐ Yes	☐ No
Do you have headaches?	☐ Yes	☐ No	Is English your first language?	☐ Yes	☐ No

Are you currently receiving any service from a Home Health Agency? ☐ ***Yes*** ☐ ***No***

Preferred Mode of Learning: ☐ Listen ☐ Written ☐ Demonstrated ☐ Handouts

Please list any other past/present medical problems/major surgeries: _____

List your current medications that you are taking: _____

List any over the counter products (vitamins, herbs, etc.): _____

Allergies to any medications, foods, or latex (rubber gloves)? ☐ Yes ☐ No If yes, please list: _____

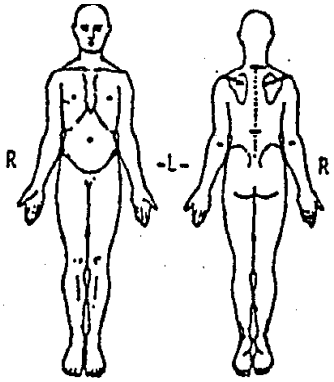
Would you be interested in nutritional counseling? ☐ Yes ☐ No

What is your **main complaint or problem** that brings you here? _____

When did it start? _____

How did it start? _____

Where is your pain located? (Please shade in areas on diagram)



Have you had any recent tests for this condition? _____

Have you had any previous treatment for this condition? _____

Has the doctor given you any specific limitations/ or guidelines to follow? _____

Are you currently employed? ☐ Yes ☐ No

☐ Full-time ☐ Part-time ☐ Light Duty ☐ Medical Leave
☐ Retired ☐ Not working ☐ Disabled

Occupation: _____ How many years on present job? _____

Was this a work related injury? ☐ Yes ☐ No

What is your current work level? ☐ Heavy ☐ Moderate ☐ Light

Do you live alone? ☐ Yes ☐ No Do you have steps? ☐ Yes ☐ No How many? _____

Have you fallen in the past 6 months? ☐ Yes ☐ No Are you able to drive? ☐ Yes ☐ No

What are your goals for your treatment here? _____

Do you have any objection to you attendant being of the opposite sex? ☐ Yes ☐ No

Do you object to having your exercises done in an open gym with other patient? ☐ Yes ☐ No

_____ _____ _____

Therapist Signature Date Patient Signature

Do not write below this line

PTEVAL