THERAPY WORKS

Medical History

Main Complaint &/or Details of Injury____

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MARK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS

□ Allergies	□ Depression	□ Mulitple Sclerosis
□ Anemia	□ Diabetes	□ Osteoporosis
□ Anxiety	□ Dizzy Spells	□ Parkinsons
□ Arthritis	□ Emphysema/Brochitis	□ Rheumatoid Arthritis
□ Asthma	□ Fractures	□ Seizures
□ Cancer____________	□ Gallbladder Problems	□ Speech Problems
□ Cardiac Conditions	□ Hepatitis	□ Strokes
□ Cardiac Pacemaker	□ High Blood Pressure	□ Thyroid Disease
□ Chemical Dependance	□ Incontinence	□ Tuberculosis
□ Circulation Problems	□ Kidney Problems	□ Vision Problems
□ Currently Pregnant	□ Metal Implants	□Other: _______________

Fall History (if applicable)

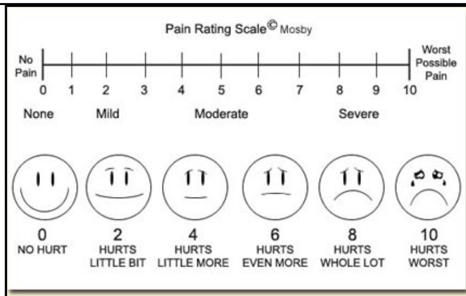
Injury as a result of a fall in the past year? ◯ Yes ◯ No If yes, date of fall_____________________
Two or more falls in the last year? ◯ Yes ◯ No Date of falls____________________________________

Surgical History (if applicable)

Body Region:___________________________Surgery Type_________________________Date of surgery____________
Body Region:___________________________Surgery Type_________________________Date of surgery____________
Body Region:___________________________Surgery Type_________________________Date of surgery____________

Current Medications / Vitamins / Supplements (if applicable)

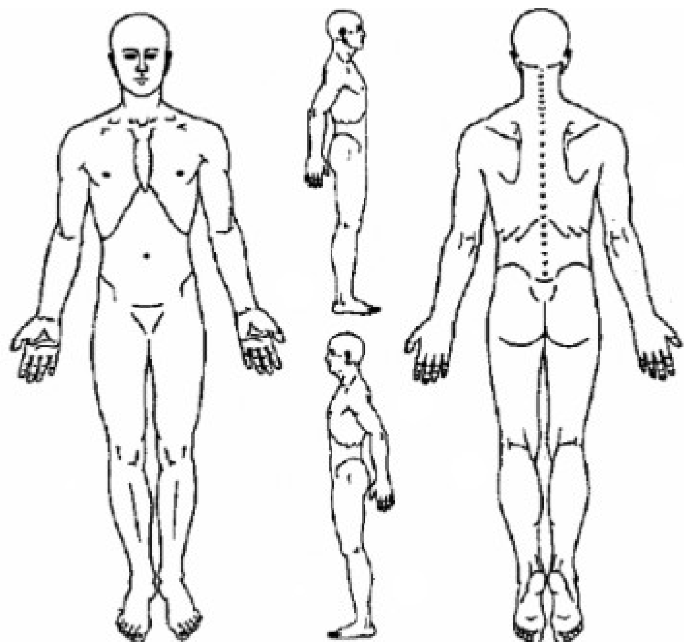
Drug:____Dosage________Reason for taking:________________________
Drug:____Dosage________Reason for taking:________________________\
Drug:____Dosage________Reason for taking:________________________
Drug:____Dosage________Reason for taking:________________________
Drug:____Dosage________Reason for taking:________________________
Drug:____Dosage________Reason for taking:________________________



Pain at Worst ___/10 Other area:________________/10
Pain at Best ____/10 Other area:________________/10
Pain Now____/10 Other area:________________/10

Please indicate the location of pain/discomfort by using the symbol(s) below that best describes what you are experiencing on the body diagram.

++ Ache **Numbness ^^Throbbing ##Tingling
== Burning !! Stabbing XX Pain
Other:____



Patient signature:_______________________Date:____/___/_____ Therapist signature:___________________________Date:___/___/_____
(Parent or Legal Guardian must sign if patient is under 18 years of age) *(History Reviewed by)*