

# Momentum Physical Therapy

## PAST MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you presently working? ☐ Yes ☐ No

Date of next physician's visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of injury / onset: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Work related injury    | <input type="checkbox"/> Recurrence of previous injury  | <input type="checkbox"/> Injury related to falling |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Injury related to lifting      | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Cause unknown          | <input type="checkbox"/> Athletic / recreational injury |  |

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Poor tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

**If yes on any of the above, please briefly explain and give approximated date:**


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


Are you presently taking Medication? ☐ Yes ☐ No

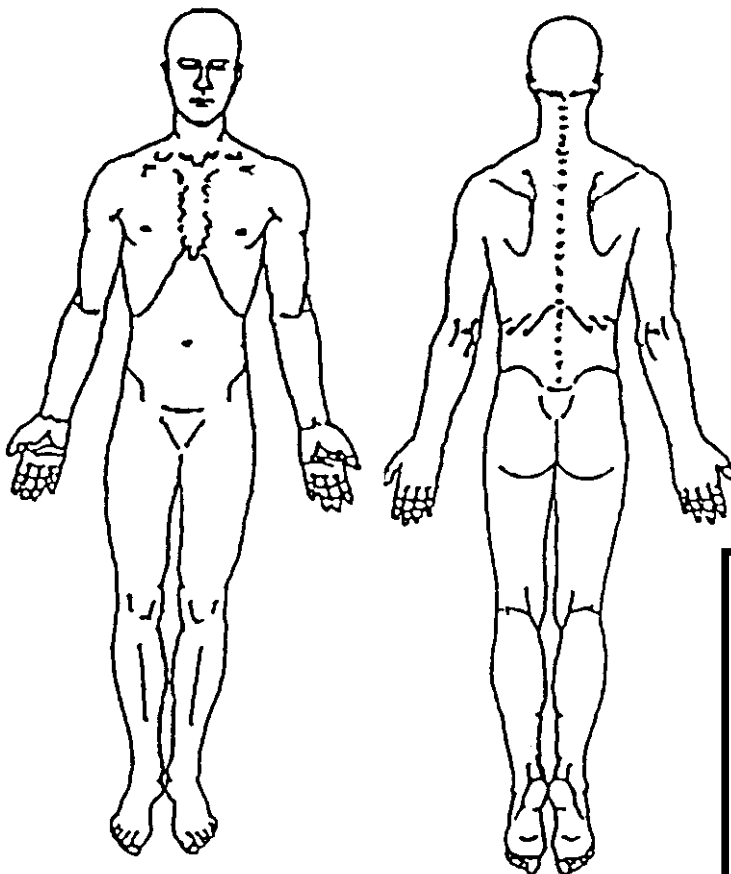
If yes, please list what medications and for what condition:


In the rare instance of an emergency, whom should we contact?

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please indicate below where your symptoms are located.



**KEY:**

**Numbness** =====

**Pins & Needles** ooooooo

**Burning Pain** xxxxxxxx

**Stabbing Pain** //////////////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: \_\_\_\_\_.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian if patient is a minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date