Biomotion Physical Therapy
Patient Medical History Form

Name: _____ Occupation: _____
Date of Birth: _____ Date of Injury: _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

Have you or an immediate family member have been told you have: (please circle yes or no)

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Angina/ Chest Pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid Arthritis?	Yes	No	Yes	No

In the past 3 months have you experienced or have had: (Please circle yes or no)

A change in your health?	Yes	No
Loss of strength or energy?	Yes	No
Nausea/ Vomiting?	Yes	No
Fever/ chills/ sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Menstrual irregularities?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No
Often been bothered by feeling down, depressed hopeless	Yes	No
Been bothered by little interest of pleasure in doing things	Yes	No

Currently, are you: (please circle yes or no)

Pregnant?	Yes	No
Depressed?	Yes	No
Under stress?	Yes	No

Currently, I have difficulty: (circle that apply)
Driving Getting up from a chair
Walking Bending at the waist
Standing Lifting

If you are accustomed to regular exercise, check the ones that are difficult now:
Playing Sports Running Calisthenics

Do you have a history of (circle that apply)
Allergies/ Asthma Headaches
Bronchitis Kidney disease
Rheumatic fever Ulcers
Sexually transmitted disease Seizures
Testing positive for tuberculosis
Living with someone who has tuberculosis

Are your symptoms: (circle one)
Getting worse The same Improving

How are you sleeping at night? (circle one)
Fine Moderately difficult
Only with medication

Do you have any problem with? (circle all that apply)
Hearing Vision Speech Communication

How do you learn best?
Seeing Doing Hearing

Do you or have in the past smoked tobacco?
Yes No
If yes,____ packs x_____ years
Last tobacco use: _____

Do you drink alcoholic beverages? Yes No
If yes,_____/week.

Date of last physical examination: _____

Past surgical history/ list all surgeries and date: _____

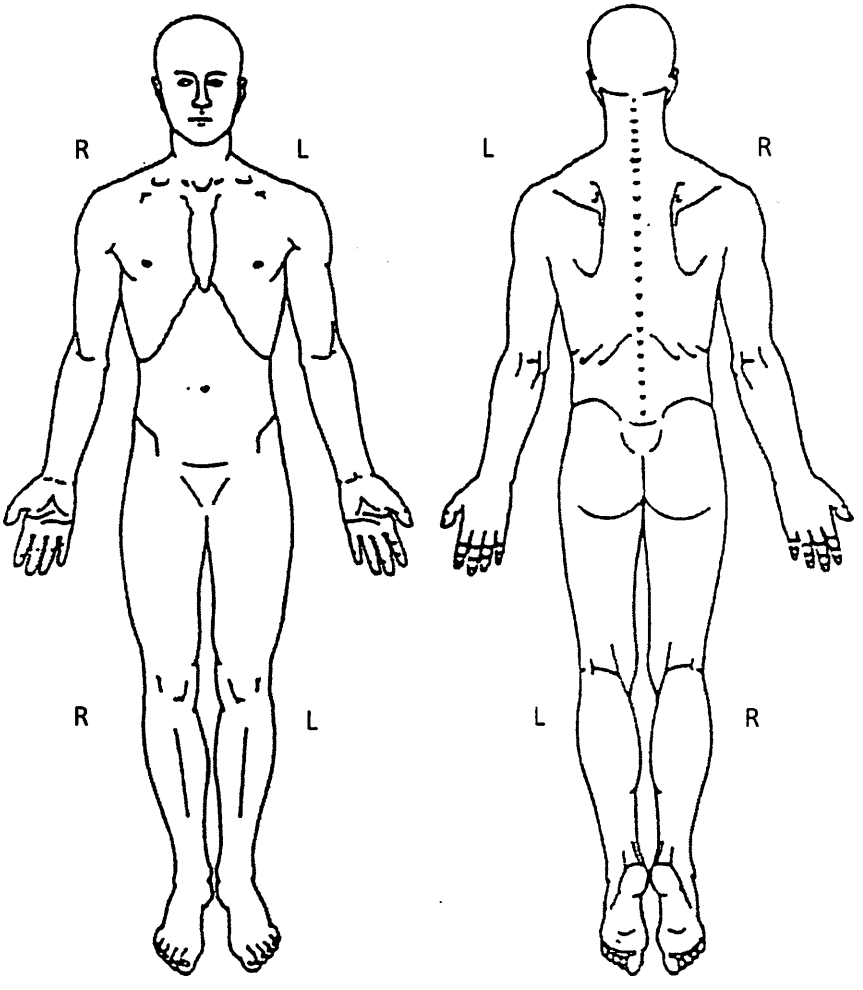
_____

List medications currently using: _____

_____

Please use the Diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

****Key: Pins and needles: 00000 Stabbing: /////**
Burning: BBBBB Ache: AAAA
Numbness: NNNNN



I believe all information to be true and complete:

Signature _____ Date _____