

# MADDEN PHYSICAL THERAPY

## MEDICAL HISTORY

**Patient Name:** \_\_\_\_\_

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

Medical History: Are you currently experiencing or have you had any of the following:

High Blood Pressure	Y N	Heart Disease	Y N	Numbness	Y N
Bowel/Bladder Problems	Y N	Pacemaker	Y N	Cancer	Y N
Shortness of Breath	Y N	Weakness	Y N	Pregnant	Y N
Female Problems	Y N	Diabetes	Y N	Dizziness	Y N
Night Pain	Y N	Fatigue	Y N	Osteoporosis	Y N
Irregular Heart Rate	Y N	Headaches	Y N	Stroke	Y N

Surgeries? Y N (List) \_\_\_\_\_

List any medications you are taking: \_\_\_\_\_

How would you rate your general health? (circle one) Poor Fair Good Excellent

In the past 3 months, have you experienced any significant changes in health (physical or mental) such as unexplained weight loss, depression, nausea, etc? (List) \_\_\_\_\_

List other medical problems: \_\_\_\_\_

Currently:

What is your current complaint? \_\_\_\_\_ When did it start? \_\_\_\_\_

Due to an injury? Y N (Explain) \_\_\_\_\_ Illness? \_\_\_\_\_

Did the symptoms begin: Suddenly or Gradually Previous problems in this area? Y N

Previous therapy for this condition? Y N What effect? \_\_\_\_\_

Are you getting: Better Same Worse Are you better with rest? Y N

Does activity make you worse? Y N Which activities? \_\_\_\_\_

Are you worse in the: Morning Afternoon Evening Is your pain: Continuous Occasional

Does your pain radiate? Y N Where? \_\_\_\_\_

What reduces your pain? \_\_\_\_\_

What can't you do because of your symptoms? \_\_\_\_\_

Recent tests: X-ray CT MRI EMG Myelogram Other \_\_\_\_\_

Results: \_\_\_\_\_

What did the Doctor tell you is your diagnosis? \_\_\_\_\_

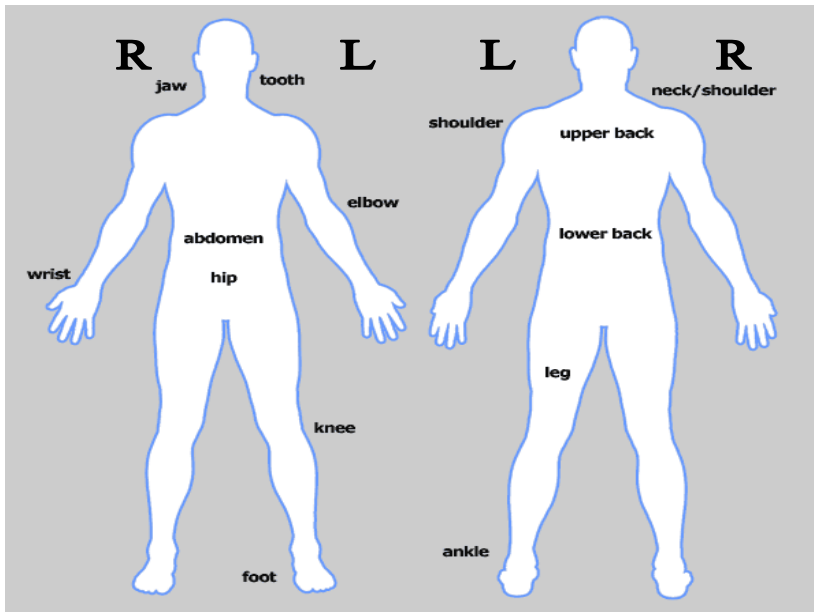
Did the physician put you on any restrictions? Y N List: \_\_\_\_\_

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain:

Right now: \_\_\_\_\_ Highest pain in past 24 hours: \_\_\_\_\_ Lowest pain in past 24 hours: \_\_\_\_\_

**PLEASE COLOR YOUR AREA OF PAIN ON THE BODY DIAGRAM BELOW**

FRONT



BACK