PHOENIX Physical Therapy
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Amherst, NY 14226
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Past Medical History

Fill out this form completely.
This is a confidential form and will be kept in your patient file.

Name: _____ DOB: _____ Today's Date: _____

Describe the reason for your visit: _____ Date of injury: _____

Phone Number:_____Would you like phone or text appt. reminders?(circle one)

Primary Care Physician:_____ Referring Physician:_____

Primary Insurance:_____ Number:_____

Secondary Insurance:_____ Number:_____

Are your symptoms? ☐ Improving ☐ Worsening ☐ Remain Unchanged

Please MARK if you have ever been diagnosis with or have:

__ Osteoarthritis
__ Rheumatoid Arthritis
__ Osteopenia
__ Osteoporosis
__ Broken Bones
__ Heart Problems
__ High Blood Pressure
__ High Cholesterol
__ Angina/Chest Pain
__ Pace Maker
__ Tendonitis
__ Bursitis
__ Neck Problems
__ Low Back Problems
__ Knee Problems
__ Hip Problems
__ Headaches/Migraines
__ Hernia
__ Diabetes
__ Fibromyalgia
__ Multiple Sclerosis
__ Parkinson's
__ Neuropathy
__ Stroke/TIA
__ Head Injury
__ Epilepsy/Seizures
__ Metal Implant
__ Allergies _____
__ Asthma
__ Emphysema/C.O.P.D.
__ Thyroid Problems
__ Cancer
Type _____
__ Chemical Dependency
__ Depression/Anxiety
__ Vision Problems
__ Hearing Problems
__ Infectious Diseases (Hepatitis, Tuberculosis, HIV/AIDS)
__ Digestive Disorders
__ GERD/Acid Reflux
__ Stomach problems/Ulcers
__ Bowel Problems
__ Bladder Problems
__ Kidney Problems
__ Skin Problems
__ Anemia
__ Blood clots/Phlebitis
__ Unexplained Weight Change (gain / loss)
__ Other _____

MARK any CURRENT symptoms:

__ Chest Pain/Shortness of breath
__ Heart Palpitations
__ Fatigue
__ Ankle Swelling
__ Dizziness or blackouts
__ Coordination Problems
__ Difficulty Walking
__ Abdominal Pain
__Recent/Current Pregnancy
__ Fever/Night Sweats
__ Difficulty Sleeping
__ Cough
__ Hoarseness
__ Difficulty Swallowing
__ Nausea/Vomiting
__ Ringing in the ears
__ Weakness
Where? _____
__ Muscle Pain
Where? _____
__ Joint Pain
Where? _____
__ Other Pain
Where? _____
__ Limited Movement
Where? _____
__ Pain at Night

List of surgeries and dates: _____

Current medications (including over the counter): _____

How would you rate your **overall health**: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

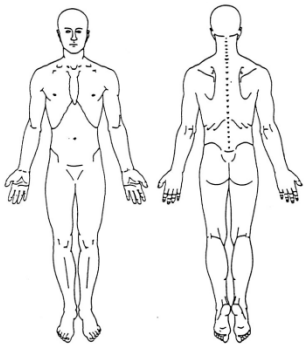
Do you smoke? ☐ Yes ☐ No how much? _____

Occupation:_____

Are you off work due to current symptoms? ☐ No ☐ Yes, since _____ ☐ Retired ☐ Unemployed

Location and Intensity of Symptoms

Pain Scale: *None 0 1 2 3 4 5 6 7 8 9 10 Unbearable*



Describe the pain:
☐ Dull OR ☐ Sharp
☐ Constant OR ☐ Intermittent
☐ Sore ☐ Throbbing ☐ Bruised ☐ Burning

What makes it better: ☐ bending ☐ sitting ☐ morning ☐ night ☐ as the day progresses
☐ turning ☐ lying down ☐ rising ☐ when still ☐ when moving
☐ what else? : _____

What makes it worse: ☐ bending ☐ sitting ☐ morning ☐ night ☐ as the day progresses
☐ turning ☐ lying down ☐ rising ☐ when still ☐ when moving
☐ what else? : _____

Have you sought treatment from the following providers in the last three months?
☐ Massage Therapist ☐ Personal Trainer ☐ another Physical Therapist
☐ Medical Doctor ☐ Osteopath ☐ Dentist ☐ Acupuncturist ☐ Chiropractor

Have you had any recent tests? You will discuss the results with your physical therapist.
☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ Blood Work ☐ Doppler Ultrasound ☐ Stress test

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Pre-examination: | Blood Pressure: / | Pulse: bpm | Height: | Weight: