

Medical History – Patient Self-Assessment

Patient Name: _____ Date: _____

Weight: _____ Height: _____ General Overall Health: **Poor** | **Fair** | **Good** | **Excellent**

Have you received any orthotics, prosthetics or back braces within the past 5 years? **Yes** | **No**

If **YES**, list item and date: _____

If **YES**, list opinion/problem with item: _____

Reason for Visit: _____

Referring Physician: _____ Last Visit: _____

Primary Care Physician: _____

Do you participate in Physical Therapy: **YES** | **NO** If **YES**, where and how often _____

Please indicate your current medical conditions:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis A or B | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Parkinson Disease |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Alzheimer Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Other: _____ |

Do you require an assistive device? **Cane** | **Walker** | **Wheelchair** | **None**

Have you had surgery within the last 5 years? **YES** | **NO** If **YES**, Date: _____

Description of Procedure: _____

Do you require assistance for Activities of Daily Living? (i.e. dressing, eating, transportation) **YES** | **NO**

Please Rate Your Pain 1-10: (No Pain) **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** (Most Pain)

Is your pain: **Long Lasting** | **Short Time** | **Constant** | **Random**

What type of work / hobbies / activities do you do? _____

What are your specific functional goals? _____