Medical History – Patient Self-Assessment

Patient Name: ____ Date: ___________________

Height: ________ Weight: ____________ 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: ____

Reason for Visit: ____

Referring Physician: ____

Primary Physician: ____

Do you participate in Physical Therapy: Yes / No If yes, where and how often _____________________________

Is your condition the result of one of the following: Work Accident / Auto Accident

If either is selected: Date of Accident _______________________ State Where Accident Occurred: ________________

Description of Accident: ____

Please indicate your current medical conditions:

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Amputation
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pulmonary Disease
- ☐ Allergies: ____________
- ☐ Vision Problems
- ☐ Parkinson Disease
- ☐ Alzheimer Disease
- ☐ Psychiatric Problems
- ☐ Alcoholism
- ☐ Hearing Loss
- ☐ Pregnant

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? ____