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: _______________________ Last Visit: ______________________________

Do you participate in Physical Therapy: **Yes | No**

If **YES**, where and how often: ____

Since your last visit, has any of your information changed? If so please notify administration and circle: **Yes | No**

If **YES**, please circle: **Insurance** | **Address** | **Phone Number(s)** | **Other (please specify):** ____________

Please indicate your current medical conditions:

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

Do you use an assistive device to help you ambulate? **None | Cane | Walker | Wheelchair**

Have you had surgery within the last 5 years, relevant for your visit today? **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? ____