PALMER PHYSICAL THERAPY for WOMEN

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PATIENT MEDICAL HISTORY FORM

Date: _____/_____ /_____

Name: _____ Age: _____ Height: _____ Weight: _____

Referring Physician: _____ Next appt. with physician: _____

Occupation/Type of Work: _____ Hours per week: _____

How did you find out about us? ☐ TV ☐ Radio ☐ Billboard ☐ Website ☐ Doctor ☐ Other _____

Medical History: Number of Pregnancies _____ Number of vaginal deliveries _____ Number of c-sections _____
☐ Hysterectomy ☐ Neck/Back Surgery ☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Osteoporosis/Osteopenia
☐ Lung/Breathing Problems ☐ Arthritis ☐ Cancer ☐ Recent Unexplained Weight Loss ☐ Current treatment to suppress immune system ☐ Pelvic Pain ☐ Urinary Incontinence ☐ Pacemaker ☐ Seizures ☐ Allergies ☐ Metal Implants
☐Stroke/CVA ☐ Kidney Problems ☐ Fractures ☐Recent Accident (if yes, explain) _____
☐ Intolerance to Heat or Cold ☐ Skin Problems ☐ Depression ☐ Other_____
Have you used a tobacco product in the past year? ☐Yes☐ No

Do you have a fear of falling? ☐Yes☐ No Have you fallen in the past year? ☐Yes☐ No (If yes, how many falls?_____)
Were you injured in a fall in the past year? ☐Yes☐ No (If yes, explain_____)

Has your physician limited your activity? ☐Yes☐ No (If yes, explain _____)

Current Medication list: Please bring a copy with you to your appointment

When did the problem(s) begin? (Date of Injury/onset)_____
Are your symptoms getting worse? ☐ Yes ☐ No

Please rate your pain level from 0 to 10
0=no pain, 1=very mild, 2=discomforting, 3=tolerable, 4=distressing,
5=very distressing, 6=intense, 7=very intense, 8=utterly horrible,
9=excruciating, 10= will go unconscious shortly

____at worst _____ at best _____on average _____ current

Does your pain radiate into your arm or leg? ☐ Yes ☐ No

If so, how far down does the pain travel? _____

Do you have numbness or tingling? ☐ Yes ☐ No

If so, where? _____

What makes your pain worse? _____

What decreases your pain? _____

Have you had these symptoms before? ☐ Yes ☐ No

Have you had prior treatment for this problem? ☐ Yes ☐ No If yes, explain:

_____

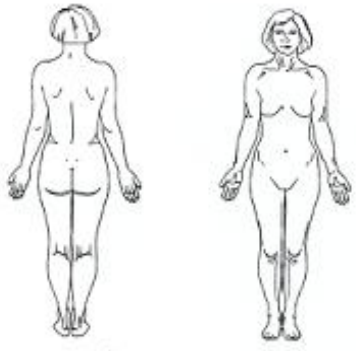
Do you leak urine? ☐ Yes ☐ No

How often do you urinate during the day? _____

Do you have painful intercourse or have pain with the use of a tampon? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____

Please Mark Location Of Your Pain



KEY: Numbness =====
Pins/Needles 000000
Burning Pain XXXX
Stabbing Pain /////

Briefly describe any additional problem(s) you are having; _____

_____

Do you participate in sports, hobbies, exercise programs, or activities? _____

Additional Comments: _____

_____