Ascent Physical Therapy Patient Medical History

Name:		Referring Physician:	
Height:	Weight:	MC patients: Have you had a fall within the last 12 months? ☐ Yes ☐ No	
Date of Injury:		Date of First Doctor Visit for this Injury:	
Have you had surgery for this injury? ☐ Yes ☐ No		Number of Surgeries: 1 2 3 4 5+	
Type of surgery:		Date of Surgery:	

Are you currently taking any prescription or non-prescription medication? ☐ Yes (Please see reverse side) ☐ No

Have you had any of the following Medical or Rehabilitative Services FOR THIS INJURY/EPISODE?

	Yes	No		Yes	No
Chiropractor	☐	☐	Neurologist	☐	☐
CT Scan	☐	☐	Occupational Therapy	☐	☐
Emergency Room Care	☐	☐	Orthopedist	☐	☐
EMG/NCV	☐	☐	Physical Therapy	☐	☐
General Practitioner	☐	☐	Podiatrist	☐	☐
Massage Therapy	☐	☐	X-Rays	☐	☐
MRI	☐	☐	Other:____		
Myelogram	☐	☐			

Please circle if you have now or have you ever had any of the following medical conditions?

Allergies	Emotional/Psychological Problems	Post Menopause
Arthritis	Emphysema	Pregnancy
Artificial Joint(s)	Gout	Regular Cough
Asthma	Headaches(Severe/Frequent)	Seizures/Epilepsy
Balance Problems	Hearing/Vision Difficulties	Stomach Problems
Blood Disorders	Heart Problems	Stroke/TIA
Blood Clot/Emboli	Heartburn/Indigestion	Thyroid Trouble/Goiter
Cancer or Chemo/Radiation	Hepatitis	Tremors
Chemical Dependency	Hernia	Tuberculosis
Circulation Problems	High Blood Pressure	Vericose Veins
Diabetes	Infectious Diseases	Weight Loss
Difficulty Breathing	Kidney Disease	Weakness
Difficulty Swallowing	Osteoporosis	
Dizziness/Fainting	Pacemaker/Defibrillator	Do you Smoke? Yes ☐ No ☐

If you circled any of the above, please explain:____

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Do you currently have or have you had any of the following symptoms relating to your injury?

Arm/Leg Swelling	Joint/Muscle Swelling	Problems Sleeping
Constipation/Diarrhea	Nausea/Vomiting	Problems Urinating
Fever/Chills/Sweats	Numbness/Tingling	Unusual Fatigue

If you circled any of the above, please explain:____

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Please list any other information that you think would assist us in your care:___________________________________

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Are you aware of what your diagnosis is?

What are your goals/expectations while in physical therapy? ____

Patient/Guardian Signature: Date: