STAR PHYSICAL THERAPY
Sports Therapy & Advanced Rehabilitation

PATIENT MEDICAL HISTORY

Patient Name _____ Referring Physician: _____

Date of First Doctor Visit for this Injury/Episode: _____ Family Physician: _____

Date Last Worked Due to this Injury/Episode: _____ Occupation: _____

Date Returned to Work after this Injury/Episode: _____ Is an Attorney involved in this case: ☐ Yes ☐ No

Have you had Surgery **on this body part?** ☐ Yes ☐ No Number of Surgeries **on this body part?** : 1 2 3

Type of Surgery: _____ Height: _____ Weight: _____

Are you currently taking any prescription or non-prescription medications? ☐ **Yes** ☐ **No**

- ☐ Anti-inflammatory drugs Drug: _____
- ☐ Muscle relaxers Drug: _____
- ☐ Pain medication Drug: _____
- ☐ Other Drug: _____

Have you had any of the following medical or rehabilitative services for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor			CT Scan		
EMG/NCV			General Practitioner		
Massage Therapy			MRI		
Myelogram			Neurologist		
Occupational Therapy			Orthopedist		
Physical Therapy			Podiatrist		
Emergency Room Care			X-rays		
Other					

Do you now have, or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, bronchitis, emphysema			Severe or frequent headaches		
Shortness of breath / chest pain			Vision or hearing difficulties		
Coronary Heart Disease / Angina			Numbness or tingling		
Do you have a pacemaker?			Dizziness or fainting		
High blood pressure			Ringing in your ears		
Heart attack or heart surgery			Weakness		
Stroke / TIA			Weight loss / Energy Loss		
Blood clot / embolism			Hernia		
Epilepsy / seizures			Tuberculosis		
Thyroid trouble / Goiter			Allergies		
Anemia			Any pins or metal implants		
Infectious diseases			Joint replacement		
Diabetes			Neck injury / surgery		
Cancer/Chemotherapy/Radiation			Shoulder injury / surgery		
Arthritis / Swollen Joints			Elbow/hand injury/surgery		
Osteoporosis			Back injury / surgery		
Gout			Knee injury / surgery		
Sleeping problems / difficulties			Leg/ankle/foot injury/surgery		
Emotional/psychological problems			Are you pregnant?		
Bowel or Bladder Problems			Do you smoke?		

List any other information that would assist us in your care: _____

Are you aware of your diagnosis? ☐ **Yes** ☐ **No**

Based on your awareness, what are your expectations/goals while in this program? _____

Patient / Guardian Signature _____ **Date** _____