

MEDICAL HISTORY

PATIENT NAME: _____ Date: _____

Date of injury/ onset: _____ Date of surgery: _____

How did your injury happen? _____

Accident Related? Auto ____ Work ____ Other ____ Right or Left Handed? _____

Occupation: _____ Working ____ Off Work ____ Light Duty ____

When do you return to your Referring Doctor? _____

Reason for attending therapy: (circle all that apply)

Motion Weakness Pain: 0 1 2 3 4 5 6 7 8 9 10

What specific activities are most difficult because of your problem?

1. _____

2. _____

Describe your health: (circle one) Excellent Good Fair Poor

Do you use tobacco: (circle one) Yes No How much? _____

Current Medications (required for Medicare):

Allergies: _____

Are you allergic to Latex? Yes No

Any previous injuries to this extremity? _____

Have you ever had any of the following conditions? (circle all that apply)

Anemia Depression Hepatitis/HIV Currently Pregnant Stroke Asthma Seizures

Kidney Problems Dizziness/Fainting Tuberculosis Cancer Fractures Respiratory Problems

Substance abuse Headaches Diabetes Metal Implants Pacemaker Osteoporosis

Low Blood Pressure High Blood Pressure (Controlled? Yes No) Cardiac problems Epilepsy

Rheumatoid Arthritis Osteoarthritis Thyroid Problems Multiple Sclerosis Insomnia

Any other medical problems? _____

The above information is accurate to my knowledge: _____

TREATMENT CONSENT

The nature of your treatment, the risks, the possible interventional alternatives and treatment goals have been discussed with you. Also, your medical history has been reviewed by the therapist to assist them in your evaluation and assessment.

I agree that DHT may provide medical information regarding this injury to my primary care physician, in addition to my referring physician.

Patient signature: _____ Date: _____ Therapists Initials _____

Therapy DX: _____

