Medical History

Patient Name: _____ Date: _____

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

How did your injury happen?_____

Do you have any open cuts, lesions or wounds? Yes No If yes, where? _____

Accident Related? Auto ____ Work ____ Other ____ Are you 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._____

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

Please list below current Medications (required for Medicare):

_____

_____

Allergies:_____ Are you allergic to Latex? Yes No

Wear glasses/contacts? YES NO Any previous injuries to this extremity? _____

Have you fallen in the past year? YES NO If Yes, How many times? _____

Did you sustain an injury as a result of the fall? YES NO

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

Anemia Depression Hepatitis/HIV Currently Pregnant Stroke Asthma

Kidney Problems Dizziness/Fainting Tuberculosis Cancer Fractures Epilepsy

Respiratory Problems Substance abuse Insomnia Headaches Diabetes Seizures

Metal Implants Pacemaker Osteoporosis Low Blood Pressure High Blood Pressure

Cardiac problems Rheumatoid Arthritis Osteoarthritis Thyroid Problems Multiple Sclerosis

Any other medical problems?_____

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 _____

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