Medical History Form

Select Therapy
Your first choice in physical therapy.

Case Information

Evaluation Date:_____ **Height:** _____ **Weight:** _____

Name:_____ **Date of Birth:**_____

Home Address:_____ **Gender:** M / F

Home Phone:_____ **Mobile Phone:**_____

Email Address:_____

Referring Provider:_____ **Primary Care Provider:**_____

Injury Information

Are you getting physical/occupational therapy as a result of a work injury or motor vehicle accident?

____No ____Yes: Work Injury ____Yes: Motor Vehicle Accident

Reason for Therapy:

____Injury Rehab ____Pain Management ____Strengthening ____Mobility / Walking

____Balance Training ____Surgical Rehab ____Other:

Approximately when did your symptoms begin? _____

How did you become injured / Did something specific happen to bring on your symptoms?

_____

Which parts of your body are affected? Check all that apply:

___Head	___Neck	___Midback / Chest / Ribs	___Low Back/Pelvis
___Shoulder	___Arm	___Elbow/Forearm	___Wrist/Hand
___Hip	___Knee	___Ankle/Foot	___Other:

Please list the medical care you have received for this injury to date (Check all that apply):

___ Medical Evaluation	___ Specialist Evaluation	___ Physical Therapy	___ Chiropractic
___ Radiographs (X-Ray)	___ MRI / CT Scan / EMG	___ Injections	___ Nerve Ablation
___ Surgery	___ Medications (Fill out chart below or provide medication list)		

Baxter Clinic
14884 Kirkwood Drive
Baxter, MN 56425
P: 218.824.5027
F: 218.824.8011

Crosslake Clinic
35544 Sandpoint Drive
Suite A
Crosslake, MN 56442
P: 218.692.5020
F: 218.692.5021

Pierz Clinic
26814 143rd Street
Pierz, MN 56364
P: 320.468.0183
F: 320.468.2075

Inver Grove Heights Clinic
5836 Blaine Avenue
Suite 105
Inver Grove Heights, MN 55076
P: 651.455.0535
F: 651.455.1565

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Medication	Dose	Method of Administration (i.e. Oral)

What type of symptoms are you experiencing?

____Pain ____Tingling/Burning ____Numbness ____Weakness

____Limited Motion ____Poor Balance ____Trouble Walking ____Difficulty completing daily activities

Please rate the severity of your pain on a scale from 0 to 10 (0 = no pain 10 = worst pain possible):

Today: _____/10 At best over last 48 hours:_____/10 At worst over last 48 hours:____/10

What types of activities / motions / positions are you having trouble with?

Activities:_____ Motions:_____ Positions:_____

Medical History:

___AIDS/HIV ___Allergies/Asthma ___Anemia / Blood Disorders ___Bladder Problems ___Bowel Problems

___Cancer ___Chemical Dependency ___Circulatory/ Vascular Problems ___Depression / Anxiety ___Epilepsy

___Diabetes Type I ___Diabetes Type II ___Headaches ___Heart Trouble ___Hepatitis

___High Blood Pressure ___Stroke ___Osteoporosis ___Osteoarthritis ___Rheumatoid Arthritis

___Kidney Problems ___Thyroid Problems ___Metal Implants ___Medical devices with a battery (Pacemaker)

Functionally speaking, what types of activities would you like to be able to do without being affected by your symptoms or related difficulties?

_____

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