# 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

# Medical History Form

Select Therapy
*Your first choice in physical therapy.*

| 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?**

_____


**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