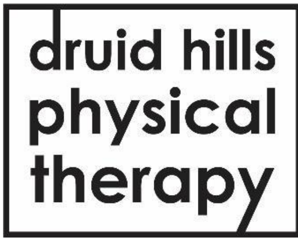


Name/Contact Information

Patient name: ________________________ Date of birth: ____________________

Address: ____

City: __________________________ State: ___________ Zip: ___________

Home phone: ____________________ Cell phone: _____________________

Work phone: ____________________ Email address: ___________________

____

Emergency contact name   Emergency contact phone #   Relationship

____ ______________________

Name of physician (referring or primary care)   Physician phone #

____ ______________________

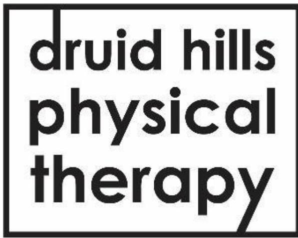
What is the date of your next scheduled visit with your physician?

____

How did you find out about Druid Hills Physical Therapy?

☐ Physician ☐ Google ☐ Saw the sign ☐ Facebook ☐ Word of mouth

Other: ____



Medical History Form

Patient Name:_______________________________________ Date:___________

What are your goals for physical therapy?

____

Please describe your physical limitations as a result of this injury or condition:

____

Please describe any activities or movements that aggravate your symptoms:

____

Please describe any previous injury or injuries that could affect care:

____

Have you had any of the following diagnostic tests in relationship to this injury?

☐ X-Ray ☐ CT Scan ☐ MRI ☐ Doppler ☐ Ultrasound

Have you received previous treatment for this injury/condition? ☐ Yes ■ No

If yes, please explain what type of treatment: ________________________________

If yes, what was the date(s) of treatment: ____________

Have you had any falls this past year? ■ Yes ☐ No If yes, how many?__________

Please describe the location of your pain:

Which of the following describes your pain? *(circle all that apply)*

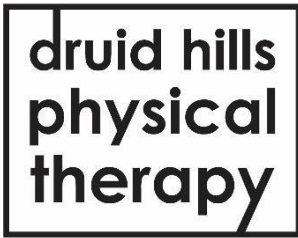
☐ *Sharp* ☐ *Aching* ☐ *Burning* ☐ *Tingling* ☐ *Numbness* ☐ *Other*

Please rate your pain: (0 = None, 1=Minimal, 10 = Severe)

At its worst: 0

At present: 0

At its best: 0



Are you currently taking medications? ■ Yes ☐ No

Please list all medications:

Have you recently noticed any of the following?

- ☐ Breathing Difficulty
- ☐ Change in Vision
- ☐ Fatigue
- ☐ Fever/Chills/ Sweats
- ☐ Insomnia
- ☐ Nausea/ Vomiting
- ☐ Pain at Night
- ☐ Pregnancy
- ☐ Weakness
- ☐ Weight Loss

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

- ☐ Allergies/Skin Sensitivity
- ☐ Asthma/Breathing Problems
- ☐ Autoimmune Deficiency
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Easy Bruising/ Bleeding
- ☐ Fainting
- ☐ Fractures
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Indigestion/ Heartburn
- ☐ Kidney Disease
- ☐ Leg/Ankle Swelling
- ☐ Loss of Consciousness
- ☐ Lung Disease
- ☐ Metal Implant
- ☐ Motor Vehicle Accident
- ☐ Multiple Sclerosis
- ☐ Osteoporosis/ Osteopenia
- ☐ Sprains/Strains
- ☐ Stroke
- ☐ Surgeries
- ☐ Thyroid Problems
- ☐ Urinary
- ☐ Problems/ Infections
- ☐ Other

Please explain and give approximate dates for any conditions marked above:

____

____

____

____

Signature of patient or guardian (if patient is a minor):________________ Date:________________