Rapha physical therapy

Past Medical History Form

Patient Name:__________________________ Date Completed:__________ Age:______

MEDICAL HISTORY:

Right / Left Handed Male / Female
Height: ________ Weight:_______
Next Doctor Visit:______________________
What is the problem you are here for?
____
Date of injury or when pain started:
____
•Date of Surgery (if applicable):_________
Check which apply to your injury:

- ☐ Work-related
- ☐ Motor vehicle accident
- ☐ Athletic / recreational injury
- ☐ Injury related to lifting or falling
- ☐ Recurrence of previous injury
- ☐ Cause unknown
- ☐ Other:______________________

•Is this the first time you have had this pain?
YES/NO If NO, then when:______________
•What treatments have you tried?
Medications, Physical Therapy, Massage, Chiropractic, Surgery
•What medications are you taking?
____

SOCIAL HISTORY:
Do you Smoke? YES NO Drink Alcohol? YES NO
Married? YES NO Children? NO YES#____
Do you regularly exercise? YES NO

WORK HISTORY:
•Are you employed? Yes NO
• Are you presently working? YES NO
IF NO, then date of last work day:_______________

•Current Occupation:____________________________

•Where are you employed:________________________

PAST MEDICAL HISTORY:
•Check which apply:

- ☐ High Blood Pressure ☐ Stroke
- ☐ Emphysema ☐ Diabetes
- ☐ Seizure Disorder ☐ Heart Disease
- ☐ Heart Disease ☐ Asthma
- ☐ Cancer

Other:_________________________________
•Female: Are you Pregnant? YES NO
•Indicate Surgeries and date or year:
____
____
____

•Check which apply:

- ☐ Chest pain ☐ Swelling
- ☐ Fatigue
- ☐ Headaches ☐ Shortness of breath
- ☐ Dizziness
- ☐ Balance Problems ☐ Fainting
- ☐ Change in bathroom habits ☐ Sleeping problems
- ☐ Significant Weight loss

Other:______________________________

PAIN AND SYMPTOMS:

Circle the answer:
•Is your pain? Occasional Continuous•
When is your pain the worst? Morning, Afternoon, Evening, Nighttime
•When is your pain the best? Morning, Afternoon, Evening, Nighttime
•Can you sleep? YES NO
•What is your best sleeping position? Side, Back, Stomach, Other,_________
•Circle the number that rates your pain *right now*: None 1 2 3 4 5 6 7 8 9 10 Go to the hospital
•Circle the number that rates you pain *at worst:* None 1 2 3 4 5 6 7 8 9 10 Go to the hospital
•Circle the number that rates you pain *at best:* None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

Rapha® physical therapy

Please check the answers that apply to you.

•*What makes your pain better?*

☐sitting ☐standing in one place ☐sleeping ☐walking ☐bending backward ☐laying flat
☐bending forward ☐other:____________________

•*What makes your pain worse?*

☐sitting ☐standing in one place ☐walking ☐driving ☐bending forward/backward
☐sleeping, laying flat ☐reaching above your head ☐walking up / down stairs