

DIAMOND PHYSICAL THERAPY PATIENT MEDICAL HISTORY

Name (PRINTED) _____ Referring Physician _____

Family Physician _____ Date of first doctor visit for this injury _____

Last date worked due to this injury _____ Date returned to work after this injury _____

Is an attorney involved in this care? YES NO
 Have you had surgery for this injury? YES NO Number of surgeries: 1 2 3 4

Type of surgery _____ Date _____

Please enter you – HEIGHT _____ WEIGHT _____ AGE _____

Are you currently taking any prescriptions or non-prescription medications? YES NO
 List Medications

Anti-inflammatories _____
 Muscle Relaxers _____
 Pain Medications _____

Have you had any of the following medical or rehabilitative services for this injury / episode?

	YES	NO		YES	NO
Chiropractor	___	___	EMG/NCV	___	___
Neurologist	___	___	Myelogram	___	___
Orthopedist	___	___	Emergency Room Care	___	___
General Practitioner	___	___	CT Scan	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	X-rays	___	___

OTHER _____

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

	YES	NO		YES	NO
Asthma, bronchitis, or emphysema	___	___	Severe/frequent headaches	___	___
Shortness of breath/chest pain	___	___	Vision/hearing difficulties	___	___
Coronary heart disease or angina	___	___	Dizziness or Fainting	___	___
Heart attack or surgery	___	___	Weight Loss / Energy Loss	___	___
Do you have a pacemaker	___	___	Hernia	___	___
High blood pressure	___	___	Allergies	___	___
Stroke /TIA	___	___	Any joint/metal implants	___	___
Blood clot/emboli	___	___	Joint replacement	___	___
Epilepsy/seizures	___	___	Shoulder injury/surgery	___	___
Anemia	___	___	Elbow/hand injury/surgery	___	___
Infectious disease	___	___	Neck/back injury/surgery	___	___
Diabetes	___	___	Knee injury/surgery	___	___
Cancer or chemotherapy/radiation	___	___	Leg/ankle injury/surgery	___	___
Arthritis/swollen joints	___	___	Are you pregnant	___	___
Osteoporosis	___	___	Do you smoke	___	___
Sleeping problems/difficulties	___	___	Difficulty/frequent urinating	___	___
Thyroid condition	___	___	Night pain	___	___

List any other information that would assist us in your care

Are you aware of your diagnosis? _____ YES NO

Would you like to speak with a social worker/vocational counselor about the aspects of your rehabilitation program? YES NO

Do you play golf? YES NO Do you play tennis? YES NO Are you a runner? YES NO

Patient or responsible party signature _____ Date: _____

I have reviewed this information with the patient.

THERAPIST (PRINTED) _____ THERAPIST (SIGNATURE) _____