



PHYSICAL AND OCCUPATIONAL THERAPY MEDICAL HISTORY FORM

PATIENT NAME _____ DATE OF INJURY _____

CAUSE OF INJURY _____ HAVE YOU HAD PT or OT THIS YEAR (CIRCLE ONE) Y / N

WHAT ARE YOU NOT DOING NOW BECAUSE OF YOUR CONDITION?

DO YOU CONSIDER YOUR PAIN (CIRCLE ONE) MILD / MODERATE / SEVERE LOCATION _____

WHAT MAKES YOUR PAIN BETTER/WORSE? _____

WHAT ARE YOUR GOALS OR WHAT DO YOU WANT TO BE ABLE TO DO THAT YOU CANNOT DO NOW? _____

DESCRIBE YOUR GENERAL HEALTH (CIRCLE ONE) GOOD FAIR POOR

DID YOU HAVE RECENT SURGERY OR HOSPITALIZATION (CIRCLE ONE) Y / N IF YES: WHEN AND WHY?

HAVE YOU HAD RECENT IMAGING FOR THIS CONDITION? (X-RAY, MRI, CT SCAN) (CIRCLE ONE) Y / N

IF YES, WHAT WERE THE RESULTS IF KNOWN _____

PLEASE LIST PERTINENT MEDICAL HISTORY (HEART AND LUNG PROBLEMS, HIGH BLOOD PRESSURE, DIABETES, AUTOIMMUNE CONDITIONS, ARTHRITIS, CANCER, PRIOR SURGERIES, ALLERGIES, ETC.)

PLEASE LIST CURRENT MEDICATIONS OR PROVIDE A LIST FOR OUR REFERENCE

AGREEMENT:

I agree to attend when scheduled. (Cancellations affect 3 people- Your Therapist, the patients wanting appointments and your recovery).

If I can't attend, I agree to allow for a 24-hour cancellation notice.

I agree to give good effort in my rehabilitation program.

If 2 scheduled appointments are missed, AHMC Rehabilitation reserves the right to discharge your treatment and notify the referring physician's office.

We agree to provide you with quality Physical Therapy and Occupational Therapy to help you achieve a higher level of performance.

Patient or Representative Signature: _____ **Date:** _____