



Longwood Rehabilitative Services

PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

Is your current injury related to: () work injury () auto accident () home accident
() sport injury () post-surgical () unsure

Injury Date: _____ Similar injury in the past? _____

Describe how your injury occurred? _____

Have you received any treatment for this injury to date? _____

List any medications? _____

Are your symptoms: () increasing () decreasing () constant

Rate your pain: 0 = no pain 10 = you would call 911 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? _____ Better? _____

Are your symptoms affecting your ability to: () work () play () sleep () sit
() stand () walk () drive () exercise

What are your goals in attending physical therapy? _____

Had any diagnostic studies for this injury? () X-Ray () MRI () CT Scan () EMG/NCV

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

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/Chest Pain	_____	_____	Vision or Hearing Difficulties	_____	_____
Coronary Heart Disease/Angina	_____	_____	Numbness or Tingling	_____	_____
Do you have a pacemaker?	_____	_____	Dizziness or Fainting	_____	_____
High Blood Pressure	_____	_____	Weakness	_____	_____
Heart Attack/Heart Surgery	_____	_____	Weight loss/Energy loss	_____	_____
Stroke/TIA	_____	_____	Hernia	_____	_____
Blood Clot/Emboli	_____	_____	Varicose Veins	_____	_____
Epilepsy/Seizures	_____	_____	Allergies	_____	_____
Thyroid/Goiter	_____	_____	Pins or Metal implants	_____	_____
Anemia	_____	_____	Joint Replacement	_____	_____
Infectious Disease	_____	_____	Neck Injury/Surgery	_____	_____
Diabetes	_____	_____	Shoulder Injury/Surgery	_____	_____
Cancer/Chemo/Radiation	_____	_____	Elbow/Hand Injury/Surgery	_____	_____
Osteoarthritis	_____	_____	Back Injury/Surgery	_____	_____
Osteoporosis	_____	_____	Knee Injury/Surgery	_____	_____
Gout	_____	_____	Leg Injury/Surgery	_____	_____
Sleeping Problems/Difficulties	_____	_____	Ankle/Foot Injury/Surgery	_____	_____
Emotional/Psychological Problems	_____	_____	Are you Pregnant?	_____	_____
Bowel or Bladder Problems	_____	_____	Do you smoke?	_____	_____

Patient/Guardian Signature: _____