

TEXSTAR PHYSICAL THERAPY  
MEDICAL HISTORY FORM

Attachment M5.002A

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

REFERRING PHYSICIAN'S NAME: \_\_\_\_\_ DATE OF INJURY OR ONSET: \_\_\_\_\_

CAUSE OF INJURY OR ONSET: \_\_\_\_\_ ARE YOU PRESENTLY WORKING? Y N

PRIMARY CARE PHYSICIAN'S NAME: \_\_\_\_\_ DATE OF NEXT MD APPT: \_\_\_\_\_

WHAT IS YOUR REASON FOR ATTENDING THERAPY: \_\_\_\_\_

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR  
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? \_\_\_\_\_

HAVE YOU RECENTLY BEEN HOSPITALIZED? YES NO IF YES, WHEN? \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL THERAPY FOR THIS CONDITION? (circle one) YES NO  
WHAT WAS DONE/WHAT WERE THE RESULTS: \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO  
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH  
FOR HOW LONG? \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> ANEMIA                            | <input type="checkbox"/> DEPRESSION         | <input type="checkbox"/> HEPATITIS/HIV       | <input type="checkbox"/> PACEMAKER            |
| <input type="checkbox"/> ARTHRITIS                         | <input type="checkbox"/> DIABETES           | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ASTHMA                            | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> KIDNEY PROBLEMS     | <input type="checkbox"/> SEIZURES             |
| <input type="checkbox"/> CANCER                            | <input type="checkbox"/> FRACTURES          | <input type="checkbox"/> LOW BLOOD PRESSURE  | <input type="checkbox"/> SUBSTANCE ABUSE      |
| <input type="checkbox"/> CARDIAC PROBLEMS                  | <input type="checkbox"/> HEADACHES          | <input type="checkbox"/> METAL IMPLANTS      | <input type="checkbox"/> THYROID PROBLEMS     |
| <input type="checkbox"/> ANY OTHER MEDICAL PROBLEMS: _____ |   |  | <input type="checkbox"/> CURRENTLY PREGNANT   |

SIGNATURE OF PATIENT: \_\_\_\_\_ REVIEWED BY: \_\_\_\_\_