

IMPACT SPORTS MEDICINE

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

Date of Injury: _____ Are you currently Working? _____

Have you had prior physical therapy for this injury? YES NO

If yes, how many visits: _____ Location: _____

Have you had Surgery for this injury? YES NO Number of Surgeries: 1 2 3 4 ____

Surgeon: _____ Type of Surgery: _____

Are You Currently Taking Any Prescription or Non-Prescription Medications? YES NO

Anti-inflammatories ____ Muscle Relaxers ____ Pain Medication ____ Birth Control Pills ____

List Medications: _____

Are You Allergic to any Medications? YES NO List Medications: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	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 or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid Disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are You Pregnant?	___	___
Emotional/Psychological Problems	___	___	Do You use Tobacco?	___	___

List any other information that would assist us in your care: _____

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO

Based on your awareness, what are your rehabilitation expectations/goals while in this program? _____

I, hereby agree and give my consent for Impact Sports Medicine to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical conditions.

Patient/Guardian Signature: _____ Date: _____