Sands Point Physical Therapy
Medical History Form

Name____**Age**_______________**DOB**________________

Preferred Language: ☐ English ☐ Spanish ☐ Other ________________
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined
Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐White ☐ Declined ☐ Other

Area of Body to be Treated: ☐ Neck ☐ Mid Back ☐ Low Back ☐ Shoulder ☐ Elbow ☐ Wrist ☐Hand ☐Fingers ☐Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Other____________

Complaints: ☐ Pain ☐ Stiffness ☐ Weakness ☐ Locking/Catching ☐Swelling ☐Tingling ☐Burning

When did your condition begin? ____________

How did your condition begin? ☐ Unknown ☐ Sports Injury ☐ Slip/Fall ☐ Other __________________

☐ Car Accident (date of accident __________) ☐ Work Accident (date of accident __________)

Have you had treatment for this condition prior to today's visit? ☐ Yes ☐ No
If yes, explain: ____
____

Current Level of pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Your symptoms have been getting: ☐ Better ☐ Worse ☐ No Change

Your Symptoms are: ☐ Constant ☐ Come and go ☐ Change on my activity ☐ Change on my position

Your Symptoms feel BETTER with: ☐ Sitting ☐ Standing ☐ Lying on back ☐ Lying on side ☐ Walking ☐ Standing Straight ☐ Bending Forward ☐ Bending Backward ☐ Other__________________

Your Symptoms feel WORSE with: ☐ Sitting ☐ Standing ☐ Lying on back ☐ Lying on side ☐ Walking ☐ Standing Straight ☐ Bending Forward ☐ Bending Backward ☐ Other__________________

Have you had any of the following testing: ☐ X-Rays ☐ MRI ☐ CAT Scan ☐ EMG ☐ Doppler

☐ Other Testing ____________

Do you have a Pacemaker or Defibrillator: ☐ Yes ☐ No

Please list any medications you are currently taking: ____
____
____

Please list any past surgeries: ____
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