General Medical History

Date:_____

COMPASS PHYSICAL THERAPY

Name:_____ Age:_____

Height:____'____" Weight:_____lbs. Diagnosis:_____

Please check (X) if you have had problems with or been treated for:

( ) Fainting or Dizziness
( ) Shortness of Breath
( ) Blood Disorders
( ) Head Injury
( ) Severe Headaches
( ) Depression
( ) Cancer
( ) Thyroid Problems
( ) Diabetes: Type ____
( ) Arthritis
( ) Rheumatoid Arthritis
( ) Multiple Sclerosis
( ) Osteoporosis
( ) Stomach Problems
( ) Muscular Weakness
( ) Joint Dislocation(s)
( ) Calf Pain with Exercise
( ) Jaw Problems
( ) Pregnancy
( ) Bowel/Bladder Problems
( ) Unexplained weight loss
( ) Difficulty Sleeping
( ) Night Pain (while sleeping)
( ) Heart Problems
( ) Pacemaker/Implanted Stimulator
( ) High Blood Pressure (Hypertension)
( ) Circulatory Vascular Problems
( ) Epilepsy/Seizures/Convulsions
( ) Constant Pain Unrelieved by Rest
( ) Infectious Diseases (i.e. TB, hepatitis, AIDS, etc.)
( ) Tingling, Numbness or Loss of Feeling? If yes, where?_____

_____

( ) Allergies:_____

What medications are you currently taking?_____

_____

Please list any past injuries, accidents or surgeries below:

Date:_____Event:_____
Date:_____Event:_____
Date:_____Event:_____

CURRENT COMPLAINT(S)

What is your primary complaint?_____

_____Date of Onset:_____

Describe the history of your symptoms:_____

_____

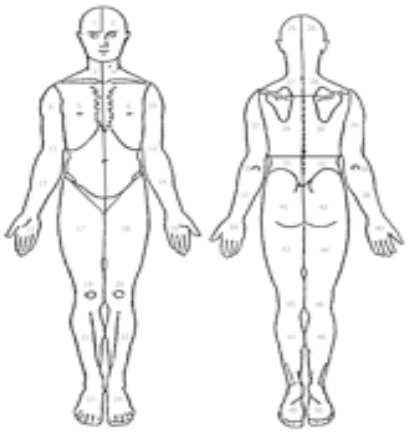
_____

Describe what you cannot do because of your symptoms:_____

_____

_____

Shade All Problem Areas



Please rate what your worst pain has been in the last 24 hours:

|----------|
No Pain Worst Possible Pain

Please indicate your stress level: Low: 0----------5----------10: High

What previous treatments or diagnostic tests have you had for these symptoms?

_____

Have you had any physical therapy visits this year? _____

If yes, who was the provider?_____

What is your occupation?_____Are you currently working?_____

What are your recreational activities and what is your exercise frequency?_____

_____

_____

What do you hope to achieve with physical therapy?_____

_____

Use backside if necessary.