PATIENT NAME: _____ REFERRING DR.: _____

OCCUPATION: _____ MARITAL STATUS M S W D O

LEISURE ACTIVITIES: _____

ALLERGIES: (medications, latex) _____

HEIGHT _____ WEIGHT_____

MIDWEST™ PHYSICAL THERAPY

Please check any of the following whose care you are under?

Medical Doctor	_____	Psychiatrist/Psychologist	_____	Other	_____
Osteopath	_____	Physical Therapy	_____		_____
Dentist	_____	Chiropractor	_____		

How many times have you had physical therapy this year and where?_____

In your own words, please describe why you are seeking physical therapy:_____

_____

If you have seen any of the health professionals in the above list during the past three months, please describe the reason (illness, medical condition, physical, etc.):_____

_____

During the past month have you been feeling down, depressed or hopeless (circle)? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think that you might be pregnant? YES NO

Operations:
Please list any surgery and approximate year

Year	**Surgery**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:
Other than operations

Year	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any PRESCRIPTION medication you are currently taking, along with dosages (including pills, injections and/or skin patches)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

☐ Not currently taking any medication.

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES	NO	Aspirin	YES	NO	Tylenol
YES	NO	Decongestants	YES	NO	Advil/Motrin/Ibuprofen
YES	NO	Antihistamines	YES	NO	Laxatives
YES	NO	Antacid	YES	NO	Vitamins/Mineral Supplements
YES	NO	Other_____			

2431 CORAL COURT #2 • CORALVILLE, IA 52241
319 • 545 • 4104 ••• Fax 319 • 545 • 4105

CAFFEINE: Do you drink (circle) caffeinated coffee, teas or sodas regularly? YES NO # per day?_____

TOBACCO: Do you use tobacco? YES NO How many packs of cigarettes do you smoke per day?_____

ALCOHOL USE: ☐ Never ☐ Occasionally ☐ Frequently

Please state how many alcoholic drinks per week you consume:_____

Have you recently noted:

YES	NO	Weight loss/gain	YES	NO	Weakness
YES	NO	Nausea/Vomiting	YES	NO	Fever/Chills/Sweats
YES	NO	Dizziness/Light-headedness	YES	NO	Numbness or tingling
YES	NO	Fatigue			

MEDICAL HISTORY: ☐ No Known Significant PMH to Affect Treatment

Have you ever had or been diagnosed to have (check any box that applies)

Cataracts		Emphysema or COPD		Degenerative Osteoarthritis	
Glaucoma		Gout		Rheumatoid Arthritis	
Asthma		Hepatitis		Bone or Joint Disease	
Allergies		Jaundice or Liver Disease		Depression	
Stroke		Metal Implants		Frequent Infections	
Seizures/Epilepsy		MRSA		Hearing impairment	
Heart Attack or Angina		Parkinson's		Palpitations	
Heart Disease		Ulcers		Chemical Dependency	
Heart Murmur		Digestive Disorder		Urinary Incontinence	
Pacemaker		Kidney Disease		Osteoporosis	
High Blood Pressure		Kidney Stones		Dementia	
Pneumonia		Diabetes (Type I or II)		Fibromyalgia	
DVT		Anemia		Lupus	
TB or Lung Disease		Thyroid Disease		Gallbladder Problems	
Bleeding Disorder		Headaches			

Cancer (type and treatment)_____

Other_____

FALL HISTORY: Have you been injured as a result of a fall in the past year?_____

Any other information you would like the therapist to know: _____

_____

_____

Signature: _____ Date: _____