



## ADULT MEDICAL HISTORY

Patient Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### REASON FOR THERAPY

Date condition began: \_\_\_\_\_ Is this a work-related injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of next doctor appointment for this condition: \_\_\_\_\_

Please describe the onset and history of the current condition(s): \_\_\_\_\_

\_\_\_\_\_

### CURRENT SYMPTOMS

Rate your symptom intensity in the past 5 days (0 is no pain or symptoms and 10 is worst possible pain or symptoms)

Symptoms at worst: \_\_\_\_\_ out of 10

Symptoms at best: \_\_\_\_\_ out of 10

### SURGERY

Did you have surgery for this condition? \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of surgery: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Please list activities that make your symptoms worse: \_\_\_\_\_

\_\_\_\_\_

Please list activities that make your symptoms better: \_\_\_\_\_

\_\_\_\_\_

What activities can you no longer do because of this condition: \_\_\_\_\_

\_\_\_\_\_

### DIAGNOSTIC TESTS

List any diagnostic tests you have received for this condition: \_\_\_\_\_

\_\_\_\_\_

### PREVIOUS THERAPY

Have you received therapy in the past 12 months? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, for what condition: \_\_\_\_\_

### MEDICAL CONDITIONS

Do you have any medical conditions that you currently suffer from or have suffered from in the past?

\_\_\_\_ Yes      \_\_\_\_ No

Check any medical conditions that you have a history of:

|                          |                         |                          |                           |                          |                  |                          |                    |                          |                      |
|--------------------------|-------------------------|--------------------------|---------------------------|--------------------------|------------------|--------------------------|--------------------|--------------------------|----------------------|
| <input type="checkbox"/> | Abnormal Bleeding       | <input type="checkbox"/> | Chronic Back Pain         | <input type="checkbox"/> | Diabetes Type II | <input type="checkbox"/> | High Cholesterol   | <input type="checkbox"/> | Osteoarthritis       |
| <input type="checkbox"/> | Angina                  | <input type="checkbox"/> | Chronic Neck Pain         | <input type="checkbox"/> | DVT              | <input type="checkbox"/> | HIV/AIDS           | <input type="checkbox"/> | Osteoporosis         |
| <input type="checkbox"/> | Anxiety                 | <input type="checkbox"/> | Closed Head Injury        | <input type="checkbox"/> | Fibromyalgia     | <input type="checkbox"/> | Hypertension       | <input type="checkbox"/> | Psoriatic Arthritis  |
| <input type="checkbox"/> | Arrhythmia              | <input type="checkbox"/> | Colitis                   | <input type="checkbox"/> | Frequent UTI     | <input type="checkbox"/> | Hypothyroidism     | <input type="checkbox"/> | PVD                  |
| <input type="checkbox"/> | Asthma                  | <input type="checkbox"/> | Congestive Heart Failure  | <input type="checkbox"/> | GERD             | <input type="checkbox"/> | IBS                | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | Bipolar Disorder        | <input type="checkbox"/> | COPD                      | <input type="checkbox"/> | Glaucoma         | <input type="checkbox"/> | Joint Pain         | <input type="checkbox"/> | Scoliosis            |
| <input type="checkbox"/> | Blood Clotting Disorder | <input type="checkbox"/> | Crohn's Disease           | <input type="checkbox"/> | Gout             | <input type="checkbox"/> | Lymphedema         | <input type="checkbox"/> | Seizure Disorder     |
| <input type="checkbox"/> | Bowel Incontinence      | <input type="checkbox"/> | CVA (Stroke)              | <input type="checkbox"/> | Heart Disease    | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> | Shortness of Breath  |
| <input type="checkbox"/> | Cancer                  | <input type="checkbox"/> | Degenerative Disc Disease | <input type="checkbox"/> | Hepatitis B      | <input type="checkbox"/> | MRSA               | <input type="checkbox"/> | Sleeping Disorder    |
| <input type="checkbox"/> | Carpal Tunnel Syndrome  | <input type="checkbox"/> | Depression                | <input type="checkbox"/> | Hepatitis C      | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> | TB                   |
| <input type="checkbox"/> | Cellulitis              | <input type="checkbox"/> | Diabetes Type I           | <input type="checkbox"/> | Hiatal Hernia    | <input type="checkbox"/> | MI/Heart Attack    | <input type="checkbox"/> | Urinary Incontinence |

### OTHER CONDITIONS

Do you have a pacemaker?      \_\_\_\_ Yes      \_\_\_\_ No      List any conditions not already included: \_\_\_\_\_

\_\_\_\_\_

### SURGERIES

Have you had any surgeries?      \_\_\_\_ Yes      \_\_\_\_ No      List surgeries you have had including date if known:

| TYPE OF SURGERY | DATE OF SURGERY | RESULTS/DETAILS OF SURGERY |
|-----------------|-----------------|----------------------------|
|                 |                 |                            |
|                 |                 |                            |
|                 |                 |                            |
|                 |                 |                            |

### MEDICATIONS

Do you take medications or over the counter supplements?      \_\_\_\_ Yes      \_\_\_\_ No

Please list current medication (includes dose and frequency if possible)

| Name | Dose | Frequency | Method (oral, injection, etc.) |
|------|------|-----------|--------------------------------|
|      |      |           |                                |

| Name | Dose | Frequency | Method (oral, injection, etc.) |
|------|------|-----------|--------------------------------|
|      |      |           |                                |
|      |      |           |                                |
|      |      |           |                                |
|      |      |           |                                |
|      |      |           |                                |

### ALLERGIES

Do you have any allergies to medications, food, or other substances that we need to be aware of? ☐ Yes ☐ No

Please provide details: \_\_\_\_\_

**Who do you live with?** (Select all that apply)

☐ Spouse ☐ Child(ren) ☐ Alone ☐ Other family members ☐ Other: \_\_\_\_\_

Is assistance provided by other who do not live in the home? ☐ Yes ☐ No

### Type of Home

☐ Single Level Home ☐ Ground Floor Apartment ☐ Assisted Living Facility ☐ Group Home  
☐ 2 Level Home ☐ Upper-Level Apartment ☐ Skilled Nursing Facility  
☐ Other: \_\_\_\_\_

### Stairs

Are there stairs to get into the home? ☐ Yes ☐ No How many? \_\_\_\_\_

Handrail? ☐ Right side ☐ Left side ☐ None

Are there stairs inside the home? ☐ Yes ☐ No How many? \_\_\_\_\_

Handrail? ☐ Right side ☐ Left side ☐ None

Is there a ramp to get into the home? ☐ Yes ☐ No

Where is the bathroom located? ☐ Main Level ☐ Upper-Level ☐ Both Levels

Where is the bedroom located? ☐ Main Level ☐ Upper-Level ☐ Both Levels

### Disability History

Are you permanently disabled? ☐ Yes ☐ No Year of disability: \_\_\_\_\_

Please describe disabilities: \_\_\_\_\_

### Smoking

Do you currently smoke? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

If yes, how many packs per day? \_\_\_\_\_

Have you smoked in the past? ☐ Yes ☐ No How many years did you smoke for? \_\_\_\_\_

How many packs a day? \_\_\_\_\_ How many years ago did you quit smoking? \_\_\_\_\_

### Alcohol

Do you drink alcohol? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

How many times per week? \_\_\_\_\_ How many drinks each time? \_\_\_\_\_

### Street Drugs

Do you use illicit drugs? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

Type of drug: ☐ Cocaine ☐ Ecstasy ☐ Heroin ☐ Pain Medications

☐ Other prescribed medications Additional Information: \_\_\_\_\_

### Work Status

What is your current work status?

☐ Employed Full-Time ☐ Employed Part Time ☐ Full-Time Student ☐ Part-time Student

☐ Retired ☐ Permanently Disabled ☐ Not Employed

What is your occupation? \_\_\_\_\_

What is your current ability to work?

☐ Able to perform all duties ☐ No formal restrictions ☐ Restricted duties/schedule

☐ Off Work ☐ Temporary Disability

Do you have any restrictions on your job duties currently due to your current conditions? ☐ Yes ☐ No

Please provide details: \_\_\_\_\_

### Work Duties (Currently able to perform)

|                               | Yes | No | N/A | D                         | Yes | No | N/A |
|-------------------------------|-----|----|-----|---------------------------|-----|----|-----|
| Sitting for extended periods  |     |    |     | Lifting heavy weights     |     |    |     |
| Standing for extended periods |     |    |     | Operating Heavy Equipment |     |    |     |
| Repetitive Bending            |     |    |     | Driving                   |     |    |     |
| Repetitive Lifting            |     |    |     | Typing/Computer Operation |     |    |     |
| Lifting moderate weights      |     |    |     | Walking                   |     |    |     |

## Equipment

Do you use any equipment to assist with mobility or daily activities? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please indicate any equipment that you use:

|  |                   |  |                          |  |                     |  |              |  |             |
|--|-------------------|--|--------------------------|--|---------------------|--|--------------|--|-------------|
|  | Cane              |  | Power Wheelchair         |  | Dressing Aid        |  | Hoyer Lift   |  | Hand Splint |
|  | Walker            |  | Scooter                  |  | Special Utensils    |  | Stair Lift   |  | Braces      |
|  | 2-Wheeled Walker  |  | Slide Board/Transfer Aid |  | Reacher             |  | Track System |  | TENS Unit   |
|  | 4-Wheeled Walker  |  | Raised Toilet Seat       |  | Power Lift Recliner |  | Stander      |  | Oxygen      |
|  | Manual Wheelchair |  | Bath/Shower Chair        |  | Hospital Bed        |  |              |  |             |

## FEEDING

Do you have any concerns related to feeding? \_\_\_\_\_ Yes \_\_\_\_\_ No

### Current Feeding Adaptations

\_\_\_\_\_ Thickened Liquids      Consistency: \_\_\_\_\_

\_\_\_\_\_ Adapted Utensils      Details: \_\_\_\_\_

\_\_\_\_\_ Adapted Seating      Details: \_\_\_\_\_

\_\_\_\_\_ Calorie Supplements      Details: \_\_\_\_\_

\_\_\_\_\_ Tube Feeding      Amount: \_\_\_\_\_      Times per day: \_\_\_\_\_      \_\_\_\_\_ Continuous      \_\_\_\_\_ Bolus

Please provide some details about these concerns: \_\_\_\_\_

\_\_\_\_\_

## MEMORY

Do you have any concerns about your memory? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please provide some detail about these concerns: \_\_\_\_\_

\_\_\_\_\_

## SPEECH

Do you have any concerns about your speech or ability to communicate with others? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please provide some detail about these concerns: \_\_\_\_\_

\_\_\_\_\_