MARIPOSA Physical Therapy Center

5072 Bullion Street
Mariposa, CA 95338
Phone: (209) 742-7272

Medical History

Date: _____

Patient Name: _____ Height:_____ Weight:_____ Age:_____

Date of Injury/Onset:_____ Surgery Date (for this injury):_____

Next Physician Appointment (for this injury):_____

Are you on a work restriction from your doctor? ☐ Yes ☐ No Are you Latex sensitive? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes - # of packs: _____ Alcohol Intake: ☐ None ☐ Light ☐ Moderate ☐ Heavy

Do you have a pacemaker? ☐ Yes ☐ No **For Women:** Are you currently pregnant or think you might be? ☐ Yes ☐ No

Current Medical History: Please 1) put a check mark next to any condition you currently have 2) put a line through any condition that you have NEVER had:

☐ Weight Loss/ Gain	☐ Muscle Weakness	☐ Difficulty with balance while walking
☐ Dizziness/Lightheadedness	☐ Change in bowel / bladder function	☐ Fainting
☐ Nausea/Vomiting	☐ Fever/Chills/Sweats	☐ Falls: Number in the past year_____
☐ Heartburn/Indigestion	☐ Cough	☐ Shortness of Breath
☐ Fatigue	☐ Numbness/Tingling	☐ Difficulty Swallowing
☐ Constipation	☐ Headaches	☐ Diarrhea

Other(s):_____

Recent illness? (explain):_____

Have you EVER been diagnosed with: (please check all that apply, AND put a line through any that do not)

☐ Cancer	☐ Heart Problem	☐ High Blood Pressure
☐ Circulation Problems	☐ Blood Clots	☐ Stroke
☐ Anemia	☐ Bone or Joint Infection	☐ Chemical Dependency (alcoholism)
☐ Depression	☐ Lung Problems	☐ Asthma
☐ Rheumatoid Arthritis	☐ Osteoporosis	☐ Bladder/Urinary Tract Infection
☐ Kidney Problems/Infection	☐ Sexually Transmitted Diseases/HIV	☐ Pelvic Inflammatory Disease
☐ Thyroid Problems	☐ Diabetes – Type 1, Type 2	☐ Multiple Sclerosis
☐ Epilepsy	☐ Ulcers	☐ Liver/Gallbladder Problems
☐ Hepatitis		

Has anyone in your immediate family (parent, brother, etc.) EVER been diagnosed with any of the following conditions?

☐ Cancer ☐ Heart Problems ☐ Diabetes- Type 1, Type 2

Explain and give approximate dates for any items indicated above:_____

_____

During the past month have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No
During the past month have you been bothered by having little interest or pleasure doing things? ☐ Yes ☐ No
Is this something with which you would like help? ☐ Yes ☐ No
Do you ever feel unsafe at home or has anyone tried to injure you in any way? ☐ Yes ☐ No

Allergies / Sensitivities (please list any you have): _____

Have you ever taken steroid medications for any medical conditions? ☐ Yes ☐ No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ Yes ☐ No

Medications (please list all medication you are taking below):

Medication Name _____ Dosage _____ Frequency _____ How Long _____ Reason _____

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What do you think caused your symptoms? _____

My symptoms are currently: ☐ Getting Better ☐ Getting Worse ☐ Staying about the same

I should not do physical activities that might make my pain worse: ☐ Agree ☐ Disagree ☐ Unsure

Treatment received for this current problem (chiropractic, injections, etc.): _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc.):_____

Have you ever had this problem before? ☐ No ☐ Yes _____

How long did it take for you to feel better after treatment? _____

My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

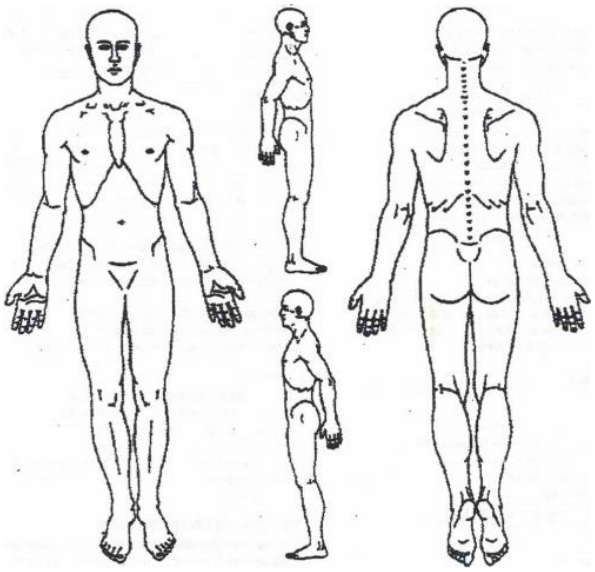
Aggravating Factors: Identify up to 3 positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

Please indicate on the chart below where your symptoms are located and if you are experiencing any tingling, numbness, burning, or pain; and if so, what kind of pain:



How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain
☐ Sleep only with medication

When are your symptoms the worst?

☐ Morning ☐ Afternoon ☐ Night ☐ After exercise

When are your symptoms the best?

☐ Morning ☐ Afternoon ☐ Night ☐ After exercise

If you are having pain, please rate your pain from 0 to 10:
0 is no pain, 1-3 is mild pain, 4-7 is moderate pain, and 8-10 is severe pain.

1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Worst level of pain	**Current level of pain**	**Best level of pain**

By signing this form, I consent to being treated for my injury by Oakhurst Physical Therapy, Inc.

Patient's Signature: _____ Today's Date:_____