MOUNTAIN STATES HAND & PHYSICAL THERAPY, INC.

PATIENT MEDICAL HISTORY

Name_____

Complete Mailing Address _____
(Street Address) (Apt #) (City) (State) (Zip Code)

Contact Phone Number: _____

Can we contact you by e-mail? Email: _____

Referring Physician_____

How did you hear about Mountain States Physical Therapy? _____

Family Physician_____ Date of Injury: _____

Have you ever had surgery for this injury? YES NO

Type of surgery_____

Are you currently taking any prescription or non prescription medications? YES NO

List Medications:_____

Are you allergic to any medications? YES NO
List medications_____

Height_____ Weight_____

Are you a tobacco user? YES NO

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Other_____

If you have Medicare, have you had any "In-Home Health Care"? YES NO

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid Disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Disease	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you pregnant?	___	___
Emotional/Psychological Problems	___	___	Do you use tobacco?	___	___

List any other information that would assist us in your care: _____

_____

Is an attorney involved in this case? YES NO

Are you aware of your diagnosis? YES NO

Based on your awareness, what are your rehabilitation expectations/goals while in this program?_____

_____ _____

Patient/Guardian Signature Date