



Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# MIDWEST PHYSICAL THERAPY AND SPORTS CENTER

*Moving you to wellness.*

## PERSONAL HEALTH HISTORY

Patient Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Family Doctor: \_\_\_\_\_

What will we be treating you for? \_\_\_\_\_

How did the injury/condition occur? \_\_\_\_\_

Injury occurred at (please circle): Home / Work / School / Church / Gym / Sporting event / Other: \_\_\_\_\_

Date of injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ OR When did you first notice symptoms? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Did you have emergency room treatment for your current injury/condition?  No  Yes

If 'Yes' where were you treated? \_\_\_\_\_

Have you had x-rays or MRI's taken?  No  Yes If 'Yes' where were they taken? \_\_\_\_\_

Please list any additional information you feel would be important to your treatment:

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No If 'Yes', how many packs per day? \_\_\_\_ Alcohol Use:  Never  Occasionally  Frequently

List all medications you are now taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to anything?  Yes  No If 'Yes', indicate what you are allergic to and how you react.

\_\_\_\_\_  
\_\_\_\_\_

Do you have or have you had: (Please check if YES)

- Arthritis                       Kidney Disease                       Rheumatic Fever                       Epilepsy
- Cancer                               Diabetes                               Stomach Ulcers                       Cortisone Drug
- Heart Trouble                       High Blood Pressure                       Blood Transfusion                       Asthma
- Tuberculosis                       Bleeding Tendency                       Nervous Breakdown                       Anemia

Past Medical History (Please list)

Surgeries/Fractures Other Major Illnesses-Injuries	Year	Hospital/Facility	Treating Physician