Agility Physical Therapy & Sports Rehabilitation

Medical History Form

Name: _____ **Date:** _____

Welcome to Agility Physical Therapy. Please answer the questions to the best of your ability. If unsure, leave blank. If you have a medication and / or a surgery list, please provide to the staff so it can be copied.

Current Issue

1. What is your main problem? _____
   _____
   _____
2. When did it start? _____
3. How did it happen? _____
4. Have you had any testing done for this problem? If yes, what type of testing (please circle if yes)
   X-ray MRI EMG CT Scan Ultrasound Myelogram Other _____
5. Have you had any of the following done for this problem? Please list date and type if applicable.
   Surgery _____ Injection _____
   Nerve block _____ Massage Therapy _____
   Physical Therapy _____ Chiropractor _____
   Brace _____ Orthotic / Inserts _____
   Other _____
6. Do you have any of the following? (please circle if yes)
   Pain Radiating Pain Numbness Tingling Swelling Stiffness
   Clicking Catching / Locking Popping Grinding Instability
7. On a scale from 0-10 with 0 being no pain and 10 being emergency room pain?
   What is your current level of pain? _____ What is the worst level of pain? _____
   What activities make you feel worse? _____
   _____
   What activities make you feel better? _____
   _____
8. What is your goal for therapy? _____
9. Who can we thank for referring you to our facility? _____

******Please Flip Over to Complete the Medical and Social History Portion*****

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www.agilityphysicaltherapy.net

Medical History

1. Please circle if you have or have had any of the following issues:

AIDS / HIV	Anemia	Arthritis	Asthma	Back Issues
Bladder Issues	Blood Clots	Cancer	Crohns / IBS	Circulation
Depression	Diabetes	Ehler's Danlos	Epilepsy	Fibromyalgia
Gout	Heart Issues	Hypertension	Kidney Issues	Liver Issues
Lung Issues	Lupus	Multiple Sclerosis	Neck Issues	Osteopenia
Osteoporosis	Pacemaker	Phlebitis	Psychological	RA
Skin Issues	Stomach Ulcer	Stroke	Thyroid issues	Tuberculosis

Other _____

_____

2. Are you taking any medications? Yes or No
   If yes, please list or provide us with a list. _____
   _____
   _____
3. Do you have any allergies? Yes or No
   If yes, please list. _____
   _____
   _____
4. Have you had any previous surgeries? Yes or No
   If yes, please list or provide us with a list. _____
   _____
   _____

Social History

1. What is your Occupation? _____
   Are you currently working? Yes or No Full-Time or Part-Time Full-Duty or Restricted Duty
2. Do you smoke? Yes or No # of packs per day _____ # of years_____
3. Do you currently participate in a sport or exercise program? Yes or No
   If yes, please describe. _____
   If no, would you like to start one? _____

_____ _____

Patient Signature Clinician Signature

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