ELLIS PHYSICAL THERAPY

Patient Medical History Form

Patient Name:______________________________ **Date:**________ **Height:**________ **Weight:**________

Describe your current complaint/condition:____

____

Patient History

How did the pain start?

- ☐ Suddenly ☐ Pulling
- ☐ Gradually ☐ Work related
- ☐ Lifting ☐ Bending
- ☐ No apparent reason ☐ MVA
- ☐ Other

Is the pain getting better/ worse/ or the same?
(circle one)

What activities make the pain worse?

- ☐ Exercise ☐ Movement
- ☐ Sitting ☐ Standing
- ☐ Walking ☐ Coughing
- ☐ Sneezing ☐ Bending forwards
- ☐ Other ☐ Bending backwards

What reduces pain?

- ☐ Lying down ☐ Resting
- ☐ Sitting ☐ Pain medications
- ☐ Standing ☐ Injections
- ☐ Walking ☐ Ice/Heat
- ☐ Nothing ☐ Other

How long have you had this pain?
____Years ____Months ____Weeks

Have you had similar pain? Yes/No

How long?
____Years ____Months ____Weeks

Have you have any imaging performed?
Yes/No: ____MRI ____X-ray ____CAT scan
When:______________________________
Where (location):______________________________

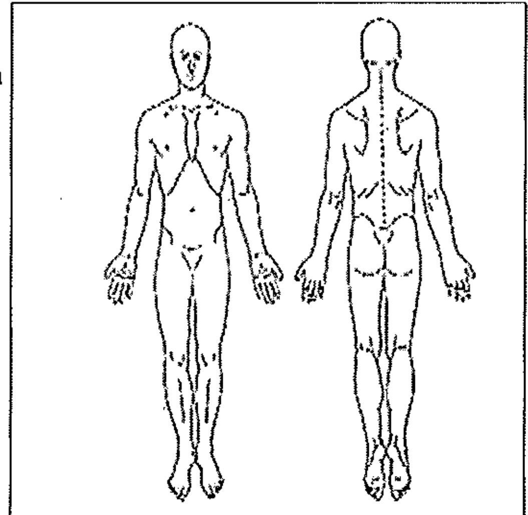
Have you been hospitalized for your condition?
Yes/No Date:______________________________

Have you had surgery for your condition?
Yes/No Date:______________________________

Have you had any other surgeries performed?
Yes/No Date:______________________________

Pain/Symptoms
On the Body Diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning



Pain Level (0-10) Circle one: 0 = No pain/ 10 = Extreme pain
0 1 2 3 4 5 6 7 8 9 10

What medications are you currently taking?

____

____

Yes/No		Yes/No	
☐ ☐	Allergies	☐ ☐	Sleeping disturbances
☐ ☐	Diabetes	☐ ☐	Do you awaken from pain?
☐ ☐	High Blood Pressure	☐ ☐	Change in bowel or bladder
☐ ☐	Heart Disease	☐ ☐	Change in stool color or rectal bleeding
☐ ☐	Pacemaker	☐ ☐	Increased thirst or hunger
☐ ☐	Stroke (CVA)	☐ ☐	Frequent urination
☐ ☐	Cancer or tumors	☐ ☐	Indigestions or heartburn
☐ ☐	Lung Problems	☐ ☐	Nausea or vomiting
☐ ☐	Arthritis/Joint pain	☐ ☐	Changes in memory
☐ ☐	Joint replacement	☐ ☐	Unusual fatigue/weakness
☐ ☐	Headaches	☐ ☐	Fever or chills
☐ ☐	Dizziness/blackouts	☐ ☐	Frequent or easy bruising or bleeding
☐ ☐	Seizures	☐ ☐	Frequent cramping
☐ ☐	Nerve disorders	☐ ☐	Are you pregnant?
☐ ☐	Visual problems	☐ ☐	Do you smoke? #/Day____
☐ ☐	Menstrual problems	☐ ☐	Do you drink? #/Day____
☐ ☐	Auto-immune disorders		
☐ ☐	Gout		

Office staff use:

PT Initials:________ **Date:**________________