



PAST MEDICAL HISTORY FORM

Patient Name _____

| BLOOD PRESSURE | | YES | NO | JOINT CONDITIONS | | YES | NO |
|-------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|--------------------------|
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper Extremity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dislocation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Normal Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lower Extremity Dislocation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART DISEASE | | YES | NO | OTHER CONDITIONS | | YES | NO |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Dystrophy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Atherosclerotic Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Myocardial Infarction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MUSCLE CONDITION | | YES | NO | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Carpal Tunnel R/L | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tennis Elbow R/L | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor Eyesight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Back/Neck Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Limited Limb Movement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Polio | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | Other: _____ | | | |
| | | | | _____ | | | |
| | | | | _____ | | | |
| | | | | _____ | | | |
| LUNGS | | YES | NO | | | | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

| EXERCISE | WORK ACTIVITY | STRESS LEVEL | HABITS | |
|--|--------------------------------------|---------------------------------|--------------------------------------|---------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sitting | <input type="checkbox"/> Low | <input type="checkbox"/> Smoking | Packs a Day _____ |
| <input type="checkbox"/> 1-2 x Week | <input type="checkbox"/> Standing | <input type="checkbox"/> Medium | <input type="checkbox"/> Alcohol | Drinks a Week _____ |
| <input type="checkbox"/> 3-4 x Week | <input type="checkbox"/> Light Labor | <input type="checkbox"/> High | <input type="checkbox"/> Coffee/Soda | Cups a Week _____ |
| <input type="checkbox"/> 5+ x Week | <input type="checkbox"/> Heavy Labor | | | |
| What types of exercise do you perform? : _____ | | | | |
| What things cause stress in your life? : _____ | | | | |

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?
 YES NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

Signature of Patient, Parent, Guardian, Personal Representative _____

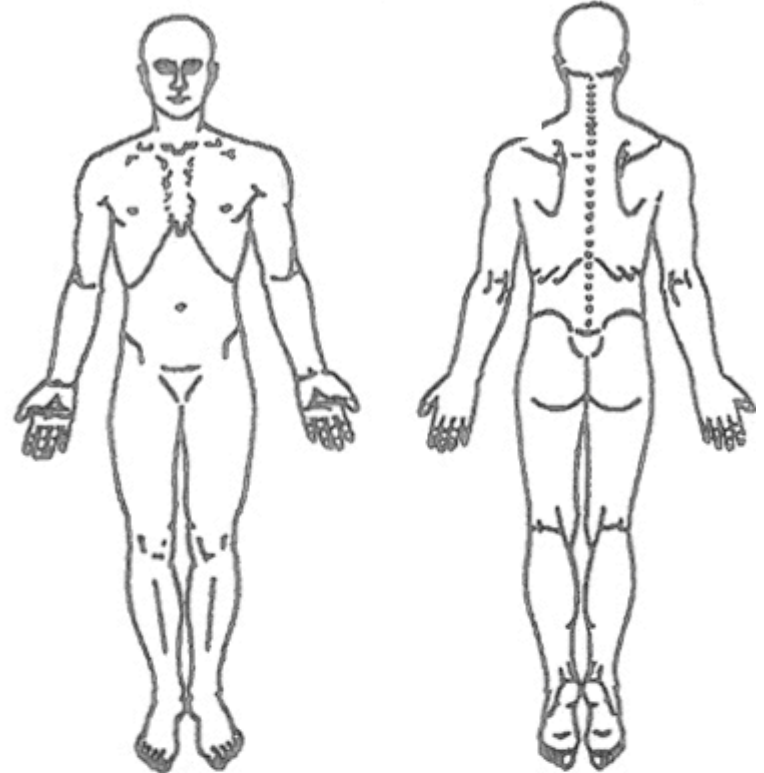
Date _____

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



Ache
MMM
M

Burning
— — —
— —

Numbness
O O O O
O O O

Pins and Needles
□ □ □ □ □ □ □ □ □ □
□ □ □ □ □ □ □ □ □ □

Stabbing
/ / / / / / / / / /
/ / / / /

Other
x x x x
x x x

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it gets.**

Additional Comments: _____