Mission Valley Physical Therapy

MEDICAL INFORMATION FORM

Name:_____Date:_____

Referring Provider: _____ Primary Provider: _____

What are we seeing you for today? _____

Date of onset: _____

List any past surgeries: _____

_____

List current medications/supplements that you take and why you take them: _____

_____

_____

_____

_____

Please mark those that apply to your current and/or past medical history:

__Alzheimer's
__Cardiovascular Disease
__Cauda Equina Syndrome
__Cerebral Vascular Accident
__Current Infection
__Diabetes Mellitus Type I
__Diabetes Mellitus Type II
__Fibromyalgia
__Fracture or Suspected Fracture
__High Blood Pressure
__Cancer
__Huntington's
__Immunosuppression
__Lupus
__Muscular Dystrophy
__Obesity
__Osteoarthritis
__Parkinson's
__Rheumatoid Arthritis
__Traumatic Brain Injury

Other: _____

How would you rate your sleep?

1 2 3 4 5 6 7 8 9 10

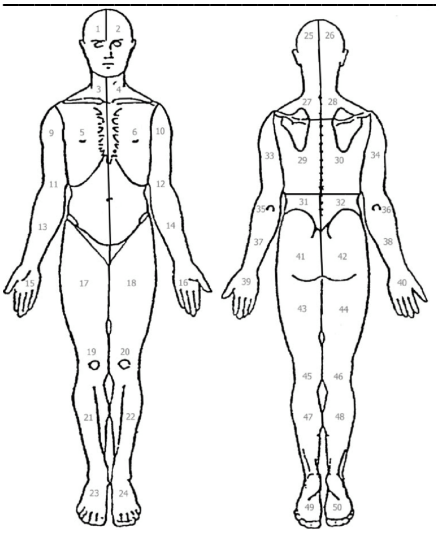
Terrible Excellent

How often do you engage in physical activity for 20 minutes or more? Please circle response

Never 1-2 times/week 3-4 times/week 5-6 times/week 7+ times/week

What are your goals for physical therapy? _____

_____



Please mark the location of your pain on the body chart.