SMaRT Therapy – Medical History

Name: _____ Date: _____
Date of birth: _____ Age: ____ Height:_____ Weight:_____ Race:___
Date of last appointment with referring physician:_____
Date of next appointment with referring physician:_____

SIGNIFICANT MEDICAL HISTORY (Please check all that apply)

__ Heart Disease	__Hepatitis	__Pacemaker	__ High blood press.
__Cancer	__HIV/AIDS	__Implants (metal)	__Arthritis
__Stroke/CVA	__Pregnant	__Asthma	__Osteoporosis
__Diabetes	__Allergies	__Vision/Hearing	__Epilepsy/Seizures

Please list all previous surgeries:
_____
_____

Current Diagnosis:

What are you here to receive physical therapy for?
__Neck __Back __Shoulder/Elbow __Arm/wrist/hand __Hip __Knee __Foot/Ankle
How long have you had your current condition? _____
Have you ever had or are you scheduled to have surgery for your current condition?
___ Yes__ No If yes, When? _____
Have you ever received an injection for this condition? __ Yes __ No
Which of the following diagnosis tests has your physician done for you?
__ X-Ray __CT Scan __Bone scan __MRI __Nerve EMG/NCV
Please list all medications you are currently taking:
_____
_____

Social History:

Are you currently working? __Yes __No where: _____
Duties/Job Description:_____
Are you working: __Full time __Part Time __Retired __Disabled __Temporary Leave
Did your physician give you any restrictions for work? __Yes __No

GOALS:

What things cant you do now because of your current condition that you use to be able to do?
_____
_____