St Mary's

Patient Medical History

To insure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank You!

Exercise routine when healthy: _____

_____

Please check if you are currently seeing any of the following health care professionals:

Medical Doctor _____ Psychiatrist/Psychologist _____ Osteopath _____
Occupational Therapist _____ Dentist _____ Chiropractor _____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

_____

_____

_____

Have you **ever** been diagnosed as having any of the following conditions? Please answer yes or no.

Cancer……_____ If YES, describe what kind:_____
Heart problems…… _____ Diabetes……..____ Depression……_____
Pacemaker……...____ Asthma……_____ Hepatitis……_____
High Blood Pressure……...____ Tuberculosis…_____ Stroke……_____
Emphysema/Bronchitis……...____ Thyroid problems….____ Kidney disease……_____
Chemical dependency……_____ Anemia……_____ Rheumatoid arthritis...____
Multiple sclerosis……_____ Epilepsy……_____ Osteoporosis……...____
Other arthritic conditions……_____ Allergies……...____

Are you currently pregnant? Yes No Due Date (if yes):_____
Have you recently experienced unexplained weight loss or gain? Yes No
Have you experienced loss of bowel or bladder control? Yes No

Are you experiencing any of the following? Please answer yes or no.

Dizziness……_____ Difficulty speaking...____ Difficulty Swallowing……_____
Drop Attacks…..____ Double Vision……..____

List any other information which would assist us with your care:_____

_____

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	**Surgery/Hospitalization**	**Reason**

Please list any x-rays or imaging that you have had done:_____

_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date	**Injury**	**Date**	**Injury**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which of the following **over-the counter** medications have you taken **in the last week**?

_____ Aspirin
_____ Tylenol
_____ Advil/Motrin/Ibuprofen
_____ Laxatives
_____ Decongestants
_____ Antihistamines
_____ Antacid
_____ Vitamins/mineral supplements
_____ Other

Please list any **prescription** medication you are currently taking, including pills, injections, and/or skin patches:

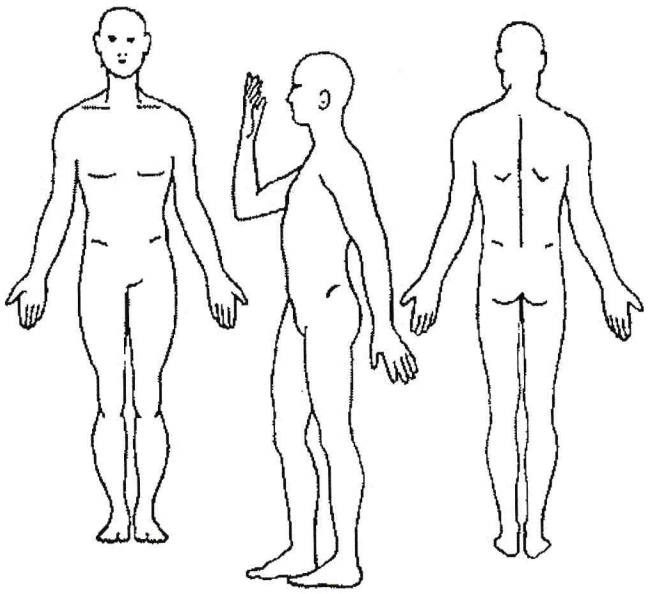
_____
_____
_____
_____
_____
_____

Please list the activities that aggravate your pain?

_____
_____

Please list your current strategies to help alleviate your pain?_____

_____



Please indicate areas of pain and discomfort (on the figures above) using the following symbols:

/// = pain
*** = numbness, no feeling at all
+ + + = tingling, asleep, abnormal feeling

Please rate your pain on a scale of 0 to 10:___
(0 being no pain, 10 being the worst pain)