Southern Maine
Physical Therapy, PA

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449 Cottage Road
South Portland, ME 04106
www.smpt.biz

MEDICAL HISTORY

Date: _____

Name: _____ Nickname: _____ Age: _____

Height/Weight: _____ Latex or Tape Allergy: ☐ Yes ☐ No

Are you seeking Physical Therapy due to accident or injury? ☐ Yes ☐ No

Date of injury: _____ Work related? ☐ Yes ☐ No Automobile? ☐ Yes ☐ No

What brought you to our clinic today? _____

Location of pain: _____ When did pain/symptoms start? _____

Is your pain worse in the: ☐ morning ☐ midday ☐ evening ☐ night ☐ other: _____

Please rate your pain on a 0 — 10 scale. 0 being no pain and 10 being excruciating.

At its best: _____ At its worst: _____ Average: _____

How would you describe your pain: ☐ aching ☐ burning ☐ throbbing ☐ stabbing ☐ other: _____

Is your pain/symptom: ☐ constant ☐ intermittent ☐ occasional ☐ only with movement or activity

☐ other: _____

What relieves your pain/condition? ☐ heat ☐ ice ☐ medication ☐ rest ☐ other: _____

What aggravates your pain/condition? ☐ walking ☐ sitting ☐ lying down ☐ exercise ☐ other: _____

Are you experiencing radiating symptoms? ☐ pain ☐ tingling ☐ numbness ☐ other: _____

If so, where? _____

Is your sleep being disturbed? ☐ Yes ☐ No Please explain: _____

Have you had previous treatment for this condition? ☐ Yes ☐ No If yes, please summarize: _____

_____

Have you had surgery for this injury / condition? ☐ Yes ☐ No If yes, what type of surgery: _____

_____

Have you had special tests related to your visit today? ☐ MRI ☐ CT-Scans ☐ X-rays ☐ Blood work ☐ other: _____

If so, when: _____ Results? _____

Other symptoms or complaints? _____

_____

Please list any additional information that would assist us in your care: _____

_____

Do you engage in regular exercise? ☐ Yes ☐ No If so, please describe: _____

What is your occupation? _____ Full or part time? _____ Hobbies _____

What are you having difficulty with functionally at home? _____

At work? _____

Are you able to enjoy your normal recreational activities? ☐ Yes ☐ No If not, please explain _____

_____

Do you walk with a cane or walker? ☐ Yes ☐ No Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? _____

Were you injured by the fall(s)? ☐ Yes ☐ No Please summarize: _____

_____

Do you live alone? ☐ Yes ☐ No Do you have family or friends to help you if needed? ☐ Yes ☐ No

Do you live in a: ☐ house ☐ apartment ☐ assisted living ☐ other: _____

Do you have stairs in your home? ☐ Yes ☐ No If so how many? _____ Is there a railing? ☐ Yes ☐ No

If we do not have a list of your prescriptions, please list them including over the counter medications. Please add the dose, and time of day you take the meds:

_____ _____ _____

_____ _____ _____

ALL PAST / PRESENT MEDICAL DIAGNOSIS:

Arthritis:	☐ Yes	☐ No	Anxiety:	☐ Yes	☐ No
Osteoporosis:	☐ Yes	☐ No	Depression:	☐ Yes	☐ No
Lyme Disease:	☐ Yes	☐ No	High Blood Pressure:	☐ Yes	☐ No
Lung Disease:	☐ Yes	☐ No	Heart Disease:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No	Tobacco use:	☐ Yes	☐ No
Shortness of Breath:	☐ Yes	☐ No	Pace Maker:	☐ Yes	☐ No
Seizures:	☐ Yes	☐ No	Chest Pain:	☐ Yes	☐ No
Neurological Condition:	☐ Yes	☐ No	Diabetes:	☐ Yes	☐ No
Parkinson's Disease:	☐ Yes	☐ No	Thyroid Disease:	☐ Yes	☐ No
Balance Issues:	☐ Yes	☐ No	Headaches:	☐ Yes	☐ No
Dizziness/Vertigo:	☐ Yes	☐ No	Unexplained Weight loss/gain:	☐ Yes	☐ No
Back or Neck Problems:	☐ Yes	☐ No	Cancer: (type: _____)	☐ Yes	☐ No
Injuries to extremities:	☐ Yes	☐ No	Abnormal Level of Fatigue:	☐ Yes	☐ No
Pregnant:	☐ Yes	☐ No	Peripheral Vascular Disease:	☐ Yes	☐ No

Other _____

What are the goals you want to achieve with physical therapy treatment? _____

_____

Signature: _____