

# Hands on Therapy - The Personal Touch

Name

Age

Date of Birth

## Lewisboro Physical Therapy, PC Medical History Form and Questionnaire

Please answer all questions as thoroughly as possible. All information will be kept confidential.

What is the primary problem (s) that you would like your physical therapist to address?

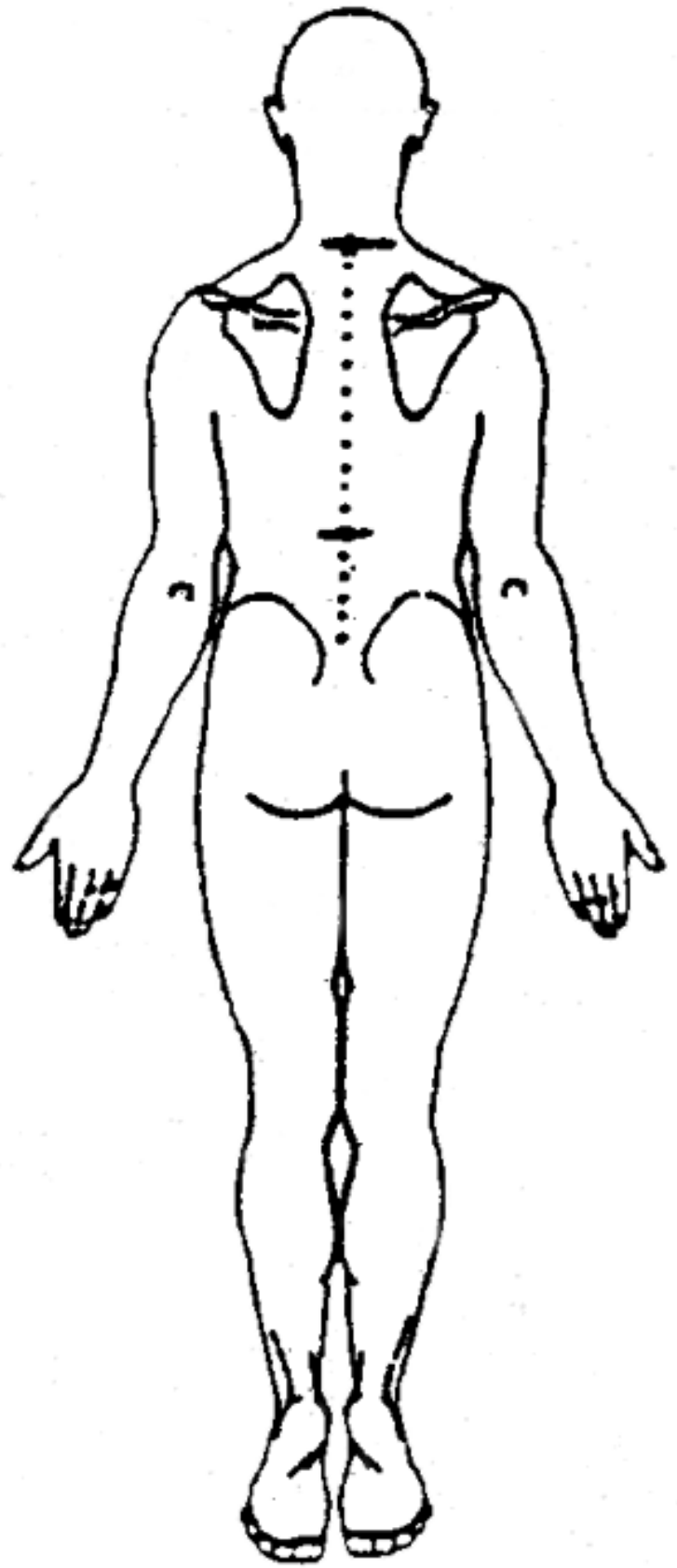
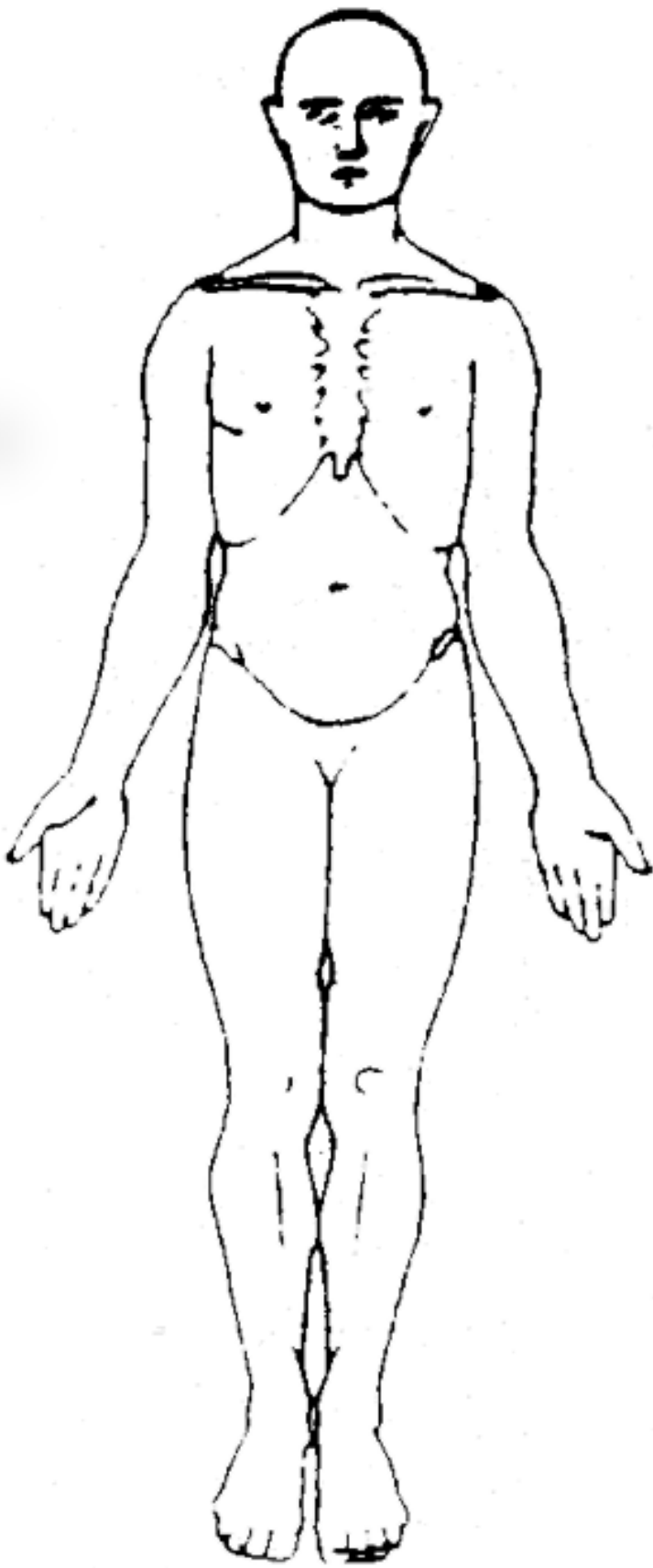
How long have you had the problem (s)?

What activities/ movements increase your pain?

What things help decrease your pain?

What is your occupation?

After printing this information, on the body chart below, please indicate with an "X" where your pain (s) or problems (s) are located.



On a scale of 1 to 10 click on which best describes your pain?

**What activities/sports do you engage in?**

**What do you hope to accomplish or gain from physical therapy?**

**MEDICAL HISTORY - Please check all conditions that you have had or currently have and explain briefly below.**

**Aids/HIV**

**Allergies**

**Anemia**

**Arthritis**

**Asthma**

**Back/Neck Trouble**

**Bleeding Disorders**

**Cancer**

**Chest Pain**

**Diabetes**

**Drug Abuse**

**Emphysema**

**Fainting**

**Fractures**

**Heart Disease**

**Heart Attack**

**Heart Murmur**

**Hepatitis**

**Herpes**

**High Blood Pressure**

**Jaundice**

**Joint Replacement**

**Liver Disease**

**Lyme Disease**

**Motor Vehicle Accident**

**Neuromuscular Disorder**

**Psychiatric Treatment**

**Seizures/Convulsions**

**Shortness of Breath**

**Stomach Ulcers**

**Stroke**

**Swelling of Hands/Feet**

**Thyroid Disease**

**Tuberculosis**

**Medications (please list)**

**Operations, Surgeries or Serious Injuries, Fractures, Strains or Dislocations (please list)**

**Are there any personal circumstances that may affect your physical therapy?**

**Please check any of the following that you may have or wear:**

<b>Glasses</b>	<b>Contacts</b>	<b>Dentures</b>	<b>Pacemaker</b>	<b>Metal Foreign Object Implant</b>
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**Please check if you are allergic to any of the following:**

<b>Latex</b>	<b>Rubber</b>	<b>Tape</b>	<b>Lotions</b>
<b>Bees</b>	<b>Strawberries</b>	<b>Shellfish</b>	<b>Cortisone</b>

**Are you pregnant or trying to become pregnant?**

**Yes No**

**Have you had any significant weight gain or loss in the past year?**

**Yes No**

**Aside from your primary care or referring physician, are you under the care of any other medical/health care provider or physician? If yes, for what condition (s)? Please provide name (s) and phone number (s).**

**Emergency contact name and number**

**To the best of my knowledge, the information provided herein is correct.**

**SIGNATURE**

**DATE**