CORE Physical Therapy
Medical History Form

To ensure 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.

Name: _____ Date: _____

Occupation: _____

Currently working: Yes No Full time: Yes No Modified duty: Yes No

Please indicate your typical level of activity: Sedentary Active Athletic

Do you exercise beyond normal daily activities and chores: Yes No

Please rate your health: Excellent Good Fair Poor Do you smoke: Yes No

Medical/surgical history

Please check if you have ever had the following:

☐ Allergies Latex: Yes / No
☐ Arthritis OA RA
☐ Broken bones/fractures
☐ Osteoporosis
☐ Blood disorders
☐ Circulation/vascular problems
☐ Heart problems Pacemaker
☐ High blood pressure
☐ Lung problems
☐ Unusual reaction to heat/cold
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Infectious disease (hepatitis, tuberculosis)
☐ Parkinson's
☐ Seizures/epilepsy
☐ Development or growth problems
☐ Thyroid problems
☐ Diabetes/high blood sugar
☐ Ulcers/stomach problems
☐ Other: _____
☐ Depression
☐ Cancer
☐ Polio
☐ Kidney problems
☐ Stroke
☐ Repeated infections
☐ Skin diseases
☐ Low blood sugar
☐ Head injury
☐ Recent Surgeries: _____
_____

Recent changes/Currently Experiencing:

(Check all that apply)

☐ Chest pain
☐ Heart palpitations
☐ Cough
☐ Hoarseness
☐ Shortness of breath
☐ Dizziness or blackouts
☐ Coordination problems
☐ Weakness in arms or legs
☐ Pregnant, or think you might be
☐ Difficulty sleeping
☐ Nausea/vomiting
☐ Difficulty swallowing
☐ Bowel/bladder problems
☐ Weight loss/gain-changes in appetite
☐ Loss of balance
☐ Difficulty walking
☐ Urinary problems
☐ Fever/chills/sweats
☐ Headaches
☐ Hearing problems
☐ Vision problems
☐ Pain at night
☐ Falling
☐ Joint pain or swelling
☐ Other: _____
☐ Current Medications (or provide list):_____
_____
_____
_____

(Continue to next page)

If you have pain, please circle the number that best represents your pain now, your worst pain, and the least pain you have experienced over the past 24 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Possible Pain

Please circle the number below which best represents your overall activity tolerance or level of function now:

Cannot do anything	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Able to do everything