SISU THERAPIES

PATIENT MEDICAL HISTORY FORM

(please fill out thoroughly)

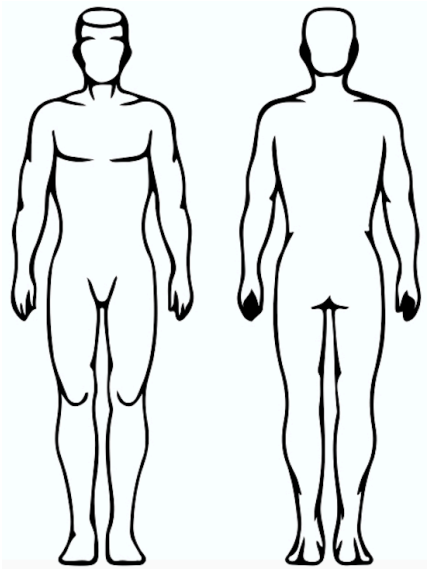
Name	Today's Date	Cell Phone	Birthdate	Emergency Contact and Phone #
Address	Email			Patient Employer: Duty: ☐ PT ☐ FT
	Have you had therapy anywhere this year? ☐ yes ☐ no If yes: # of visits _____ Are you getting in home care? ☐ yes ☐ no			Is this condition: 1. Fall related? ☐ yes ☐ no 2. Automobile related? ☐ yes ☐ no 3. Work related? ☐ yes ☐ no

How do you learn best?	Do you have difficulty:
☐ hearing ☐ seeing ☐ doing	☐ hearing ☐ seeing ☐ speaking ☐ reading

How did you hear about us? (circle)

☐ doctor referred (write name): ☐ tv commercials ☐ drive by ☐ been here before ☐ friend ☐ other:

WHAT ARE WE SEEING YOU FOR TODAY?_____



DATE OF INJURY/ACCIDENT: _____

DATE OF SURGERY: _____

What type of symptoms are you having?

Symptoms are:

☐ constant ☐ intermittent ☐ chronic ☐ new

☐ getting better ☐ getting worse ☐ same

Where is your pain?

Mark on the person where your pain is and note type of pain.

Pain Intensity:

____/10 at worst ____/10 current ____/10 at best

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — MODERATE PAIN — SEVERE PAIN

Pain gets better with:_____

☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

Pain gets worse with:_____

☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

What is limited because of current complaint:_____

☐ sleep ☐ self-care ☐ housework ☐ reaching ☐ lifting ☐ sitting ☐ standing ☐ bending ☐ community access ☐ work

What are your goals for therapy?_____

Any other notes:

-MEDICAL HISTORY-

Medical History		
check all that apply:	☐ Rheumatoid Arthritis	☐ Traumatic Brain Injury
☐ No known significant PMH to affect treatment	☐ Diabetes Mellitus Type 1	☐ Immunosuppression
	☐ Diabetes Mellitus Type 2	☐ Lupus
☐ Alzheimers	☐ Fibromyalgia	☐ Muscular Dystrophy
☐ Cardiovascular Disease	☐ Fracture of Suspected Fracture	☐ Obesity
☐ Cauda Equina syndrome	☐ High Blood pressure	☐ Osteoarthritis
☐ Cerebral Vascular Accident	☐ History of Cancer	☐ Parkinson's
☐ Current Infection	☐ Huntington's	☐ Other:

Please list ALL				
Surgeries/injections.				
Imaging related to injury Check and date:	☐ Xray	☐ CT Scan	☐ MRI	☐ other:
Other practitioners you have seen for treatment:				
Falls or traumas:				
Do you have allergies to:	☐ latex ☐ cold ☐ heat ☐ medications		Any other allergies?	

List current medications/vitamins/supplements: You can bring in a document containing this if you wish.

Name	*Purpose*

Health Considerations:

Smoking: ☐ currently ☐ history

Alcohol: ☐ currently ☐ history __drinks/week

Pregnancy: ☐ currently __# of weeks along __# of total pregnancies

To the best of my ability, I have included all pertinent medical information. I also give consent to receive therapy by qualified staff and/or participate in fitness or physical activity opportunities.

Patient/Guardian Signature: _____ Date: _____

-Sisu Therapies thanks you for your completeness; we promise it will help give you great care!

SISU THERAPIES