



## Patient Health Record

Bring in on your evaluation day or fax to (508) 647-1634

Patient Name: \_\_\_\_\_

### Current Medical History

Reason for Physical Therapy: \_\_\_\_\_

Date of injury or surgical date: \_\_\_\_\_

Is this a result of a motor vehicle/work accident related? YES NO

If yes, is an attorney or liability insurance involved? YES NO

### Past History

Has the patient ever been hospitalized? YES NO

If yes, please describe: \_\_\_\_\_

Has the patient ever had surgery? YES NO

If yes, please describe: \_\_\_\_\_

### Medications

(Please list all current meds including prescription, over the counter, and herbal supplements)

### Allergies

(Please list all allergies that the patient has)

**Has the patient had or does the patient have any of the following?** (Please circle all that apply)

Abnormal blood pressure

Epilepsy/ seizure disorder

Pacemaker

AIDS

Fainting

Polio

Anemia

Fractures

Psychiatric Care

Arthritis

Hearing problems

Respiratory disease

Artificial Joints

Heart problems

Stroke

Asthma

Hepatitis

Thyroid disease

Bleeding disorder

Kidney problems

Tuberculosis

Bowel/Bladder Problems

Liver problems

Ulcers

Cancer

Open wounds

Visual problems

Diabetes

Osteoporosis

### Sports

Does the patient participate in sports? YES NO

If yes, what sport(s), and how often? \_\_\_\_\_

**Recreation/ hobbies**

Please indicate any other recreational activities or hobbies: \_\_\_\_\_

Please describe any other information you feel would be useful for the therapist to know:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Our Pediatric Patients ONLY**

**School**

Grade in school: \_\_\_\_\_

School patient attends: \_\_\_\_\_

**Birth History (for patients under 5)**

Vaginal delivery \_\_\_\_\_ Cesarean section \_\_\_\_\_

Full term \_\_\_\_\_ Preterm \_\_\_\_\_

Birth weight \_\_\_\_\_

**Other services currently receiving**

Physical Therapy? YES NO

If yes, please indicate:

Early Intervention: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

At School: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

Other: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

Occupational Therapy? YES NO

If yes, please indicate:

Early Intervention: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

At School: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

Other: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

Speech Therapy? YES NO

If yes, please indicate:

Early Intervention: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

At School: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

Other: \_\_\_\_\_ How often? \_\_\_\_\_ Last visit? \_\_\_\_\_

Other services? YES NO

Please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_