CATALYST
PHYSICAL THERAPY

PAST MEDICAL HISTORY PATIENT FORM

Patient Name: _____ **Date:** _____

Are you presently working? ☐ Yes ☐ No **Date of next physician's visit:** ___/___/___

Date of injury / onset: ___/___/___ **Have you ever had physical therapy for these symptoms before?** ☐ Yes ☐ No

Check which apply to your symptoms:

☐ work related injury
☐ motor vehicle accident
☐ injury related to falling
☐ recurrence of previous injury
☐ injury related to lifting
☐ athletic / recreational injury
☐ other: _____

Have you had a related surgery in the past? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No
Diabetes	☐	☐
Chest Pain / Angina	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Heart Attack	☐	☐
Heat Palpitations	☐	☐
Pacemaker	☐	☐
Headaches	☐	☐
Kidney Problems	☐	☐
Are you pregnant?	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Bowel / Bladder Abnormalities	☐	☐
Urine Incontinence	☐	☐
Asthma / Breathing Difficulties	☐	☐
Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐
Smoking	☐	☐
Other:	☐	☐

	Yes	No
Allergies to Aspirin	☐	☐
Allergies to Heat	☐	☐
Allergies / Poor tolerance to Cold	☐	☐
Other Allergies	☐	☐
Hernia	☐	☐
Seizures	☐	☐
Metal Implants	☐	☐
Dizziness / Fainting	☐	☐
Recent Fracture	☐	☐
Surgeries	☐	☐
Skin Abnormalities	☐	☐
Sexual Dysfunction	☐	☐
Nausea/ Vomiting	☐	☐
Ringing in your ears	☐	☐
Special Diet Guidelines	☐	☐
Hypoglycemia	☐	☐
Stroke/CVA	☐	☐

If yes, please briefly describe your symptoms:

Is there any other information about your medical condition that we should know about?

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Are you presently taking medication? ☐ Yes ☐ No

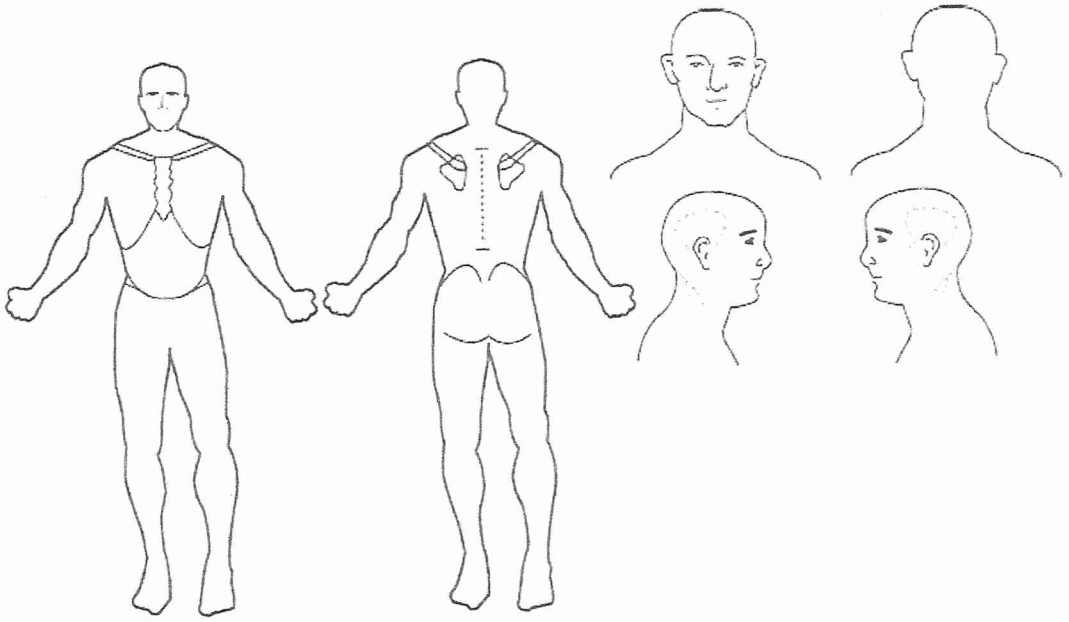
If yes, please list and describe medications taken:

In case of an emergency, whom should we contact?

Name: _____ **Relation:**_____
Phone Number: _____

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe _____

Please indicate below where your symptoms are located.



If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

_____ ___/___/___ _____
Patient's Signature Date Signature of Guardian (if patient is a minor)

_____ ___/___/___
Therapist Signature Date

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