



Patient Medical History

Name: Referring Doctor:
Email: Injured Body Part:
Twitter: Have you had surgery for this injury?
Occupation: Type/Date of Surgery:
Have you had previous PT for this injury? Is this injury a result of a work or car accident?
If Yes, When? Height: Weight:
General Activity Level:

Please list Type, Dosage, AND Route (Oral, Topical, etc.) of ALL prescription AND over the counter medication herbals, vitamins, minerals, or nutritional (dietary) supplements that you are currently taking:

Please indicate if separate medication/dosage/route list is attached:

Table with 6 columns: Type, Dosage, Route, Type, Dosage, Route. Three rows of empty fields for medication listing.

Please "X" any of the following whose care you are under:

General Practitioner: Osteopath: Neurologist:
Physical Therapist: Orthopedist: Psychiatrist/Psychologist:
Speech Pathologist: Chiropractor: Other (please specify):

If you have seen any of the following in the past 3 months, please describe for what reasons (illness, medical condition, physical, etc.)

EMERGENCY CONTACT NAME AND PHONE:

I authorize Sports Physical Therapy of New York, PC to contact my emergency contact in case of emergency.

Please indicate your Current level of pain:

No pain

Worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Please indicate your pain when it is at its Worst:

0 1 2 3 4 5 6 7 8 9 10

Please indicate your pain when it is at its Best:

0 1 2 3 4 5 6 7 8 9 10

Please list all the major surgeries, illnesses, injuries, and fractures that you have had in the past

How much caffeinated coffee or caffeine-containing beverages do you drink per day?

How many packs of cigarettes do you smoke per day?

How many days per week do you drink alcohol?

How many alcoholic drinks per day?

Are you on a special diet? Describe:

Are you having difficulty sleeping? Normal hours of sleep: Current hours of sleep:

Do you have any religious or cultural needs that may require attention during your rehabilitation?

Describe:

Please describe current symptoms:

When did your symptoms first appear?

Please describe three activities that you are unable to perform without symptoms due to this condition:

1)

2)

3)

Is there anyone that can assist you with doing home exercises or activities, if needed?

Do you anticipate having any problems attending physical therapy sessions?

Please list any sport or leisure activities that you participate in:

Patient Signature:

Date:



Sports PT of NY Medical History Checklist:

Please check YES or NO	YES	NO	DESCRIBE
Cancer (if yes please describe type)			
Breast lump			
Malaise (overall sick feeling)			
High blood pressure			
Controlled by medication?			
Heart problems (if yes describe type)			
Pacemaker			
Diabetes (if yes please describe type)			
Controlled by diet?			
Controlled by medication?			
Controlled by exercise?			
My diabetes is not controlled.			
Circulation problems			
Blood clots			
Asthma (if yes please describe type)			
If exercise induced do you have			
an inhaler? (Please bring at every visit)			
Chemical dependency (i.e. Alcoholism)			
Thyroid problems			
Stroke			
Multiple Sclerosis			
Rheumatoid Arthritis			
Severe/Frequent headaches			
Kidney disease			
Anemia			
Epilepsy/Seizure disorder			
Tuberculosis			
Hepatitis			
Depression			
Osteoporosis			
Hernia			
Joint Replacement (please describe type/date)			
Vision difficulty			
Hearing difficulty			

