Hilton Head Physical Therapy

General Medical History Form

Patient Name: _____ Age: _____ Date: _____

Referring Physician: _____

Please Answer the Following Questions

1.	Have you received a therapy assessment or treatment within the current year?	Y / N
2.	Are you currently under Home Health Care or Hospice?	Y / N
3.	Have you had surgery for this injury within the last 8 weeks?	Y / N
4.	Have you had a cast removed from the injured body part within the last 2 weeks?	Y / N
5.	Is this injury the result of a workplace accident?	Y / N
6.	Is this injury the result of a motor vehicle accident that has occurred within the last 90 days?	Y / N

To Rule Out Contraindications to Treatment, Mark An "X" In the Appropriate Box If You Have Ever Suffered Any of The Following Health Problems.

__Seizures/Stroke __Bleeding Problems __Diabetes __Osteoporosis __Blood Clots
__Blood Pressure __Chest pain/Angina __Cancer __Anemia __HIV
__Pacemaker __COPD

Indicate with an "X" Which of the Symptoms Below You Presently Suffer From.

__Shortness of Breath. __Nausea/Vomiting __Numb/Tingling
__Difficulty Swallowing __Changes in Bowel Function __Changes in Bladder
__Increased Pain at Night __Fever/Chills/Sweats __Dizziness

History of Present Injury

What part of your body is presently injured? _____

When/How were you injured? _____

How were you referred to us? __Physician __Friend, if so whom? _____
__Print Ad __ Previous experience with clinicians

Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

Acknowledgement

I have completed this form to the best of my knowledge and ability

_____ _____

Signature Date