Apex Physical Therapy Medical History Form

PATIENT INFORMATION		PHYSICIAN INFORMATION
Patient Name:		Primary Physician:
Date: / /	Age:	Referring Physician:

CURRENT INJURY

Body part(s) to be treated:

Onset: Sudden ☐ Gradual ☐ | Date of injury OR Duration of symptoms:

If you had an injury, briefly describe how the injury occurred:

Have you had a similar symptoms before: Yes ☐ No ☐

Who have you seen for your current condition:
Primary MD ☐ Orthopedic MD ☐ Other MD ☐ PT ☐ Chiropractor ☐

What Tests or Procedures have been done for your current condition:
X-Rays ☐ MRI/CT Scan ☐ Bone Scan ☐ EMG ☐ Blood Work ☐ Other ☐

What Treatment has been performed for your current condition:
No Treatment ☐ Medication ☐ Injection(s) ☐ PT ☐ Surgery ☐ Date: / /

What medications are you taking for your current condition (prescribed or over the counter):

1)_____ 2)_____ 3)_____ 4)_____

What was your primary reason for choosing Apex:
MD highly recommended Apex ☐ MD gave you a choice of clinics ☐ Family/Friend ☐
Insurance In-Network ☐ Convenient location ☐ Website/On-line review ☐

OCCUPATION

What is your occupation:_____ OR ☐ Homemaker ☐ Retired ☐ Student

Are you currently employed (excluding homemaker): Yes ☐ No ☐ *if yes* F/T ☐ P/T ☐

My work primarily involves: Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐

HOBBIES OR LEISURE ACTIVITIES (please list any physical hobbies or leisure activities)

GENERAL FITNESS LEVEL

How would you describe your current fitness level: Excellent ☐ Good ☐ Fair ☐ Poor ☐

How often do you exercise weekly: None ☐ 1-2x ☐ 3-4x ☐ 5+ ☐

General stress level: Low ☐ Moderate ☐ High ☐ Overwhelmed, feeling hopeless ☐

APEX PHYSICAL THERAPY

Apex Physical Therapy Medical History Form *continued...*

PAST MEDICAL HISTORY (Please check "yes" if you have ever been diagnosed with…)

Note: If you are unsure about a particular item, please leave it blank and discuss this with your therapist

	YES	NO
Auto-Immune Disease		
Systemic Arthritis (RA, Lupus, Other)	☐	☐
Unexplained rashes, sores or swelling	☐	☐
Fibromyalgia/ Chronic Fatigue	☐	☐
Blood Disorders		
Bleeding disorders	☐	☐
Clotting disorders	☐	☐
History DVT (Blood Clots)	☐	☐
Currently taking blood thinners	☐	☐
Peripheral vascular disease	☐	☐
Cancer		
History of cancer, any type	☐	☐
Cardiovascular		
Heart Attack	☐	☐
Chest pain or Angina	☐	☐
Fainting	☐	☐
Heart rate restrictions w/ ex. (per MD)	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Osteoporosis	☐	☐
Immunologic		
HIV	☐	☐
HEP B, HEP C	☐	☐

	YES	NO
Neurologic		
Stroke/TIA	☐	☐
MS/Parkinsons	☐	☐
Seizure disorder	☐	☐
Poor balance with frequent falls	☐	☐
Recent tremors or clumsy walking	☐	☐
Numbness/tingling both hands or feet	☐	☐
Pulmonary		
Asthma	☐	☐
Shortness of breath with exercise	☐	☐
Require the use of an inhaler	☐	☐
Other		
Currently pregnant (or think you might be)	☐	☐
Do you have a pacemaker	☐	☐
Do you have metal implants	☐	☐
Severe cold intolerance/Raynauds	☐	☐
Poor tolerance to NSAID's	☐	☐
Severe food or drug allergies	☐	☐
Vision or hearing difficulties	☐	☐
Constitutional symptoms (Current)		
Fever/ chills/ nights sweats	☐	☐
Severe fatigue/malaise	☐	☐
Nausea/vomiting	☐	☐
Dizziness/fainting	☐	☐
Unexplained weight loss, >10% BW	☐	☐

Other: please include recent hospitalizations or any other information that you think would be beneficial in helping us with your care:

To the best of my knowledge, the information above is accurate.

Signature: _____ Date:_____

Relationship to Patient:_____