PEAK
PHYSICAL THERAPY

Medical History

Today's Date:_____ Patient Name:_____ Phone Number:_____
How did you hear about us:_____

General Information

1. Is this injury related to? ☐Work ☐ Car Accident☐ Other Liability/Potential Lawsuit ☐Not Applicable
2. Do you have a Primary Care Physician / Family Doctor? ☐No ☐Yes
   If yes, have you had an appointment with him / her in the last 12 months? ☐No ☐Yes

If you are a Medicare beneficiary, you are required by Medicare to answer the following question:

3. Do you consume more than 7 alcoholic drinks in a week? ☐ Yes ☐ No

Please Mark One Box For Each Item	No	Yes Under a year	Yes Over a year	If Yes, explain	**Please Mark One Box For Each Item**	No	Yes Under a year	Yes Over a year	If Yes, explain
Smoking	☐	☐	☐		Sexual dysfunction	☐	☐	☐	
Diabetes	☐	☐	☐		Bladder / bowel problems	☐	☐	☐	
Heart condition	☐	☐	☐		Groin numbness	☐	☐	☐	
High blood pressure	☐	☐	☐		Arthritis	☐	☐	☐	
Chest pain	☐	☐	☐		Osteoporosis	☐	☐	☐	
Stroke	☐	☐	☐		Psychological condition	☐	☐	☐	
Kidney condition	☐	☐	☐		Seizures	☐	☐	☐	
Blood clot / DVT	☐	☐	☐		Dizziness / faintness	☐	☐	☐	
Metal implants / pacemaker	☐	☐	☐		Ringing in ears	☐	☐	☐	
Breathing difficulties / asthma	☐	☐	☐		Allergy to latex (gloves)	☐	☐	☐	
Cancer	☐	☐	☐		Other allergy	☐	☐	☐	
Difficulty swallowing	☐	☐	☐		Head Injury	☐	☐	☐	
Circulation/vascular problems	☐	☐	☐		Obesity	☐	☐	☐	
Peripheral neuropathy	☐	☐	☐		Chronic pain/fibro/headaches	☐	☐	☐	
Unexplained weight loss	☐	☐	☐		Fractures	☐	☐	☐	
Double vision	☐	☐	☐		Infection	☐	☐	☐	
Night sweats / night pain	☐	☐	☐		Fever / nausea	☐	☐	☐	
					Are you pregnant?	☐	☐	☐	

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Patient Medication List

Please list ALL medications (including prescription, over –the-counter, vitamins, dietary or nutritional supplements.) which you may be taking routinely and/or on an as needed basis. If you have a list you may attach it or bring it with you to your initial evaluation.

Medication	Dosage	Frequency	Route of Administration

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS/Parkinson's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐Spine☐ Upper Extremity ☐Lower Extremity

Patient Name_____ Height:_____ Weight:_____
Date of Injury _____ Date of Surgery _____

History of Injury (How, when, pain level, where) _____
_____

Pain right now (0-10) _____ Pain at worst _____ Pain at best _____

Describe the pain (sharp, deep, dull, etc) _____

What makes your pain worse?_____

What makes your pain better?_____

Previous Treatment/Testing_____

How is the injury limiting your daily activities/hobbies?_____
_____

Where do you live/with whom (ages of children)?_____
_____

Occupation: Full or Part time (circle one) Please describe your work duties: _____
_____
_____

Goals for physical therapy_____
_____

Any other injuries/surgeries (not listed on previous page)_____
_____
_____

History of Falls _____
_____
_____

Any injuries resulting from fall? Please explain _____
_____