MIAMI PHYSICAL THERAPY ASSOCIATES INC.
2869 SW 27 Avenue • Miami, FL 33133
Tel: 305-444-0074 • Fax: 305-444-8503
www.miamipta.com

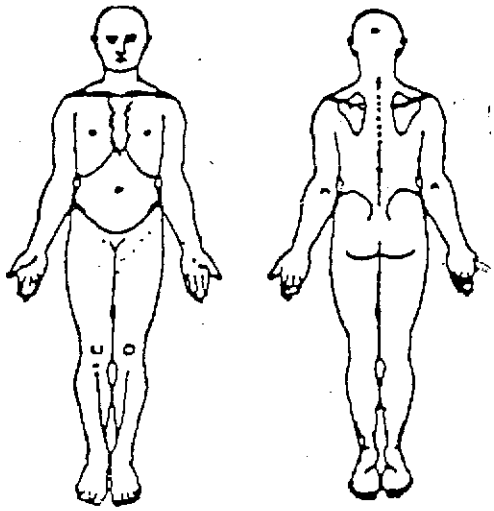
MEDICAL HISTORY

Welcome to our office! To better assist in your rehabilitation please answer the following questions. **Thank you for taking the time to fill out this form completely.** All information provided by you is strictly confidential and becomes part of your medical records.

Name_____ Age: _____ Height: _____ Weight: _____ Date: _____

What is the problem for which you are seeking physical therapy services? Please explain:

Are you having painful symptoms at this time? Yes No. Please describe where your pain is using the following diagram and symbols. X=pain, O=tingling, Δ=throbbing, >=burning.



What makes your pain better?

What makes your pain worse?

Have you been cautioned by any doctor regarding restrictions or abstinence from any activity?

MEDICAL/SURGICAL HISTORY
Please check if you have ever had:

__Arthritis
__Broken bones/fractures
Where? _____
__Osteoporosis
__Blood disorders
__Circulation/vascular Problems
__Heart problems
__High blood pressure
__Kidney problems
__Repeated infections
__Multiple Sclerosis
__Muscular dystrophy
__Parkinson disease
__Seizures/epilepsy
__Thyroid problems
__Cancer
Where?_____
__Infectious disease (e.g. hepatitis, tuberculosis)
__Any metal implants
__Other _____
__Head injury
__Spinal cord injury
__Hypoglycemia
__Diabetes
__Ulcers/stomach problem
__Skin Diseases
__Depression
__Pacemaker
__Lung problems
__Stroke

What medications are you presently taking?

1. 3.
2. 4.

Within the past year, have you had any of the following symptoms?

__Chest pain
__Heart palpitations
__Cough
__Shortness of breath
__Dizziness or blackouts
__Coordination problems
__Weakness in arms or legs
__Loss of balance
__Difficulty sleeping
__Loss of appetite
__Nausea/vomiting
__Difficulty swallowing
__Bowel problems
__Weight loss/gain
__Urinary problems
__Fever/chills/sweats
__Difficulty walking
__Headaches
__Joint pain or swelling
where? _____
__Hearing problems
__Visions problems
__Pain at night
__Falls
__Other:_____

Have you ever had surgery? YES NO If yes, please describe and include dates:

_____ Month _____ Year _____
_____ Month _____ Year _____
_____ Month _____ Year _____

Do you have a history of: __drug abuse __alcohol abuse __sexual abuse

Please list any allergies:

1. 3.
2. 4.

When do you return to your doctor? _____

Are you seeing anyone else for this problem? (i.e. acupuncturist, chiropractor)

Are you involved in litigation due to your present condition? Yes No

Are you presently employed? Yes No. What activities do you need to perform in this setting:
Desk Work_____ Use a computer_____Performing lifting activities_____Driving_____
Standing for long periods of time_____ other _____

FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply.)
Do you have difficulty with the following?

__Bed mobility
__Transfers (such as moving from bed to chair, from bed to toilet)
__Walking
__on level ground __on ramps
__on stairs __on uneven terrain

__Difficulty with self-care (such as bathing, dressing, eating, toileting)
__Difficulty with home management (such as household chores, shopping, driving)
__Difficulty with community and work activities/integration
__work/school __recreation or play activity