

MEDICAL HISTORY

Name: (First) _____ (Middle Initial) _____
(Last) _____

Prescription Medications / Supplements: _____

Allergies: _____

Surgeries: _____

BEND & STRETCH
Pilates | Physical Therapy
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CURRENT SYMPTOMS: (Check all that apply)

- Chest Pain
- Coordination Problems
- Decreased range of motion in : _____
- Difficulty concentrating
- Difficulty sleeping
- Headaches
- Hearing Problems
- Loss of balance
- Pain at night
- Loss of bowel control/incontinence
- Headaches
- Numbness/tingling at: _____
- Dizziness
- Visual problems
- Weakness in: _____
- Arthritis in: _____
- High Blood Pressure
- Other (major illness/recurrent issue) _____
- Head injury/trauma
- Broken bones _____
- Circulation problems
- Lung problems
- Depression
- Parkinson’s disease
- Thyroid conditions
- Kidney problems
- Osteoporosis
- Heart Problems
- Stroke
- Heart Attack
- Low blood sugar/hypoglycemia
- Seizures/Epilepsy
- Skin Disorders
- Infections disease (HIV, TB, Hep C, etc)
- Diabetes Type: _____
- Cancer: _____

What brings you to therapy today? _____

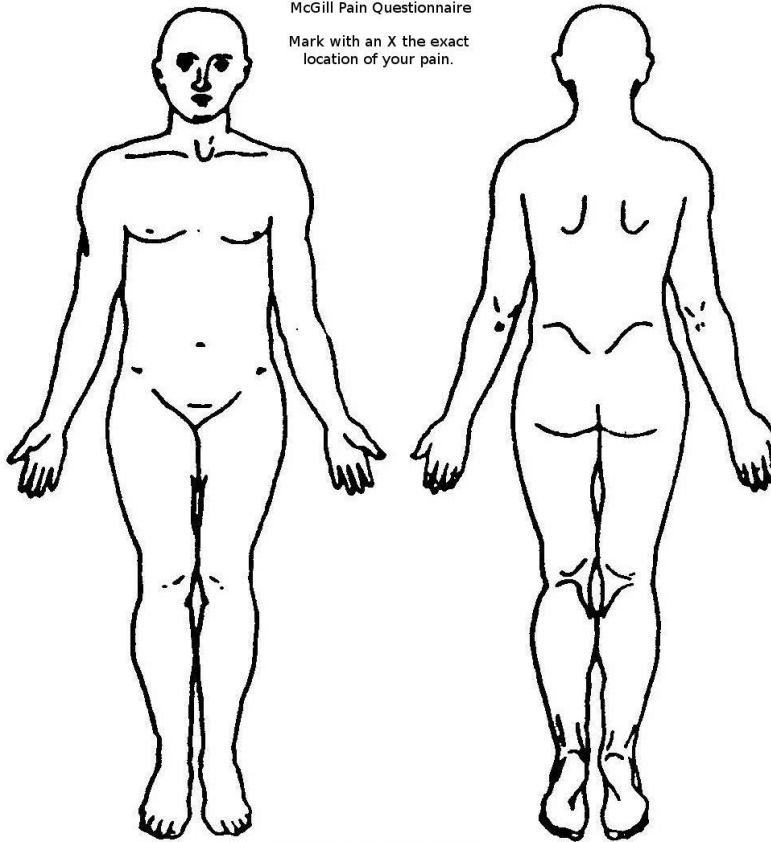
When did your symptoms begin? _____
On a scale 0 to 10, with zero being “no pain” and 10 being “the most excruciating pain possible”, please indicate your pain level today: _____ at best over the past week: _____ at worst over the past week: _____

What makes your symptoms WORSE: _____

What makes your symptoms BETTER: _____

McGill Pain Questionnaire

Mark with an X the exact location of your pain.



(Melzack & Torgerson, 1971)

Smoking? ____ Yes ____ No

Have you had any previous treatment for your current condition? (acupuncture, chiropractic, PT, Massage, etc) _____

Have you had any diagnostic imaging studies (x-rays, MRI, CT Scans, US.....)? _____

What do you do for physical activity/exercise? _____

How many hours/week? _____

What are your recreational activities/hobbies? _____

What are your goals for Physical Therapy?

1. _____
2. _____
3. _____

Patient: _____ Date: _____

Parent/Guardian (if patient is under age of 18) _____ Date: _____