Brief Medical History

(Federal regulations require that a medical history must be included in all patients' medical records)

Name: ____ Height:______Weight: ______ Referring Dr. __________________________________

Have you had Occupational Therapy for your present condition? Yes ☐ No ☐ When?__________Where?____

Briefly describe how your condition occurred:
____

Pain/Symptoms

On a scale from 0 to 10, (0 = no pain, 10 = high enough pain to go to the emergency room), what is your

Current pain level?____/10 Your **highest** pain level? ____/10 Your **lowest** pain level?____/10

List any factors that make your condition worse/better:

Worse____**Better** ____

Please check any of the health conditions that apply to you:

☐ Anxiety/Panic Disorder
☐ Asthma
☐ Back Pain /neck pain, low back pain, degenerative disc diseases, and spinal stenosis
☐ Cancer
☐ Chronic Obstructive Pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
☐ Depression
☐ Diabetes type 1 or 2
☐ Fracture or suspected fracture
☐ Gastrointestinal Disease /ulcer, hernia, reflux, bowel liver, gall bladder

☐ Headaches
☐ Hearing impairment
☐ Heart Disease / Heart Attack, Myocardial Infarction, Congestive heart failure, Pacemaker, Internal defibrillator, angina
☐ Hepatitis/HIV/AIDS
☐ High Blood Pressure
☐ Kidney/ bladder, prostate, urination problems or incontinence
☐ Neurological Disease
☐ Osteoporosis
☐ Peripheral Vascular Disease
☐ Pneumonia (recent)
☐ Previous Accidents
☐ Alcohol Use: Never Rarely Moderate Daily

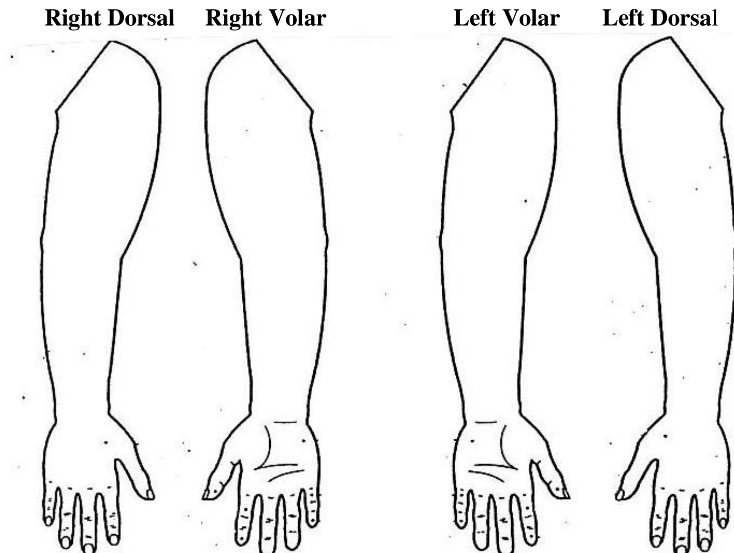
☐ Prior surgery
☐ Prosthesis/Implants or metal plates
☐ Sleep Dysfunction
☐ Seizures
☐ Stroke/TIA
☐ Thyroid
☐ Visual impairments (such as cataracts, glaucoma, macular degeneration)
☐ Other Disorders ____________________________

Females: Pregnant? Yes ☐ No ☐

☐ Tobacco Use: Never Quit Currently Smoke___ Packs/day Year started smoking_____

If you checked any of the above conditions, please explain briefly and give approximate dates:
____

Please list current medications you are taking:
____



On the arm diagram, please indicate your region of pain using the following symbols:

(X) Sharp

(+) Numbness/tingling

(#) Dull/aching

(B) Burning

Patient Signature:______________________________
Date: ______________________________