Atlas Physical Therapy and Industrial Rehabilitation

Medical History: **Existing or Relevant Previous Conditions**

Allergies	◯Yes◯No	Dizzy Spells	◯Yes◯No	MRSA	◯Yes◯No
Anemia	◯Yes◯No	Emphysema/Bronchitis	◯Yes◯No	Multiple Sclerosis	◯Yes◯No
Anxiety	◯Yes◯No	Fibromyalgia	◯Yes◯No	Muscular Disease	◯Yes◯No
Arthritis	◯Yes◯No	Fractures	◯Yes◯No	Osteoporosis	◯Yes◯No
Asthma	◯Yes◯No	Gallbladder Problems	◯Yes◯No	Parkinson's	◯Yes◯No
Autoimmune Disorder	◯Yes◯No	Headaches	◯Yes◯No	Rheumatoid Arthritis	◯Yes◯No
Cancer	◯Yes◯No	Hearing Impairment	◯Yes◯No	Seizures	◯Yes◯No
Cardiac Conditions	◯Yes◯No	Hepatitis	◯Yes◯No	Smoking	◯Yes◯No
Cardiac Pacemaker	◯Yes◯No	High Cholesterol	◯Yes◯No	Speech Problems	◯Yes◯No
Chemical Dependency	◯Yes◯No	High/Low Blood Pressure	◯Yes◯No	Strokes	◯Yes◯No
Circulation Problems	◯Yes◯No	HIV/AIDS	◯Yes◯No	Thyroid Disease	◯Yes◯No
Currently Pregnant	◯Yes◯No	Incontinence	◯Yes◯No	Tuberculosis	◯Yes◯No
Depression	◯Yes◯No	Kidney Problems	◯Yes◯No	Vision Problems	◯Yes◯No
Diabetes	◯Yes◯No	Metal Implants	◯Yes◯No		

Describe any other conditions:

If "Yes" to any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History:

Injury as a result of a fall in the past year? ◯Yes◯No

Two or more falls in the last year? ◯Yes◯No

Patient is at risk for falls? ◯Yes◯No

Surgical History:

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Patient Signature: _____ **Date:** _____

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Current Medications: ☐ **Currently not taking any medication**

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

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Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

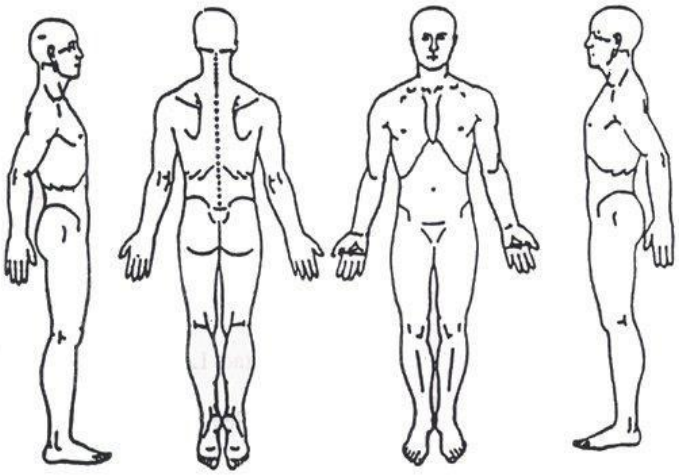
What is your primary complaint? Body Region: _____ Onset Date: _____

What is your pain level for the above body region? 0 (No Pain) to 10 (Emergency Room) _____

What has helped relieve the symptoms for the above body region? _____

Please Circle all that apply: Pain Stiffness Numbness (less feeling) Tingling (pins & needles) Weakness

On the diagram below, please indicate your primary complaint(s):



Please mark activities that you feel you are unable to perform or have difficulty performing, due to the above chief complaint(s).

Sleeping: ____ Standing/Prolonged Standing: ____ Sitting/Prolonged Sitting : ____ Pushing: ____ Reaching: ___ Walking: ___

Housework: ____ Yard work: ____ Gym: ____ Sports: ____ Hiking: ____

Patient Signature: _____ Date: _____