



Patient General History Form

Name: _____ Nickname: _____
DOB: ___/___/___ Age: _____ Height: _____ Weight: _____
Family Physician: (Name/City) _____

Body Part to be treated: _____ Right or Left
Injury due to:

Sports: ___ Yes or ___ No; What sport? _____
Work: ___ Yes or ___ No; Job Title: _____
If work related injury, in which state is your employer located: _____
MVA: ___ Yes or ___ No; Insurance issued in what state? _____

Are you currently receiving Home Health Care Services? ___ Yes or ___ No

Date of injury/accident/onset of initial symptoms: _____

How did you become injured?

Describe current symptoms and their location, and if they have changed since they first occurred:

Past Medical History: Check Yes or No. Yes _____ No _____

High Blood pressure

Kidney Disease

Diabetes

If yes, indicate (Type I/Type II)

___ Type I ___ Type II

TB

Hepatitis

Cancer

If yes, specify type, date and location: _____

Other Medical History: _____

Family medical history and surgeries:

Medications: ___ Yes or ___ No; If yes, please specify

Allergies (Drug, or any general allergies): Please specify and reaction you had.

Patient Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____