BE Fit
PHYSICAL THERAPY

Returning Patient Medical History Form

BE Fit. BE Well.

Name: _____ **DOB:** _____ **Today's Date:** _____

What brings you here today? _____

When did your condition begin? _____

When was your most recent doctor's appointment for this condition? _____

Do you have a scheduled follow-up with your physician? If so, what is the date of your next follow-up?_____

Have you had this condition in the past? *Yes No*

Have you had any other treatment for this condition (currently or in the past)? Yes No If yes, Please check:

Surgery CT scan Other: _____

Medications MRI Have you ever had Physical Therapy for this condition? ◉ ○

Injections X-ray If Yes, What were the Approximate Dates of PT: _____

____Chiropractic care

What are your goals for PT? _____

Are you *Right* or *Left* hand dominant? Right

Pain Scale:		***Best/No Pain***									***Worst/ Extreme Pain***
Today's Pain:	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*	☐ *5*	☐ *6*	☐ *7*	☐ *8*	☐ *9*	☐ *10*
Your Worst Pain:	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*	☐ *5*	☐ *6*	☐ *7*	☐ *8*	☐ *9*	☐ *10*
Your Avg. Pain:	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*	☐ *5*	☐ *6*	☐ *7*	☐ *8*	☐ *9*	☐ *10*

At the present time, would you rate your overall general health as (please circle): *excellent good fair poor*

Medicare Patients:

Have you had an injury as a result of a fall in the past year? ○○ Date of fall:_____

Have you had two or more falls in the last year that did not result in injury? ○○ Date of falls:_____

**** You need only to complete the following if you have had any *CHANGES* to your history already on file.****

Current Medications (Dosage is required for all Medicare beneficiaries): *** Have a copy of this? Let us scan it for you.*

Drug: _____ Dosage:_____ Frequency/Route:_____ Purpose:_____

Drug: _____ Dosage:_____ Frequency/Route:_____ Purpose:_____

Drug: _____ Dosage:_____ Frequency/Route:_____ Purpose:_____

Over Please

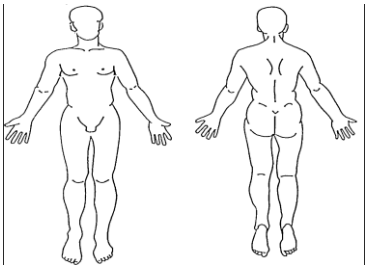
****Only complete if *CHANGES* to your Current History on file****

Please circle all conditions that you have, or have had in the past.

Allergies	Yes No	Dizzy Spells	Yes No	Metal Implants	Yes No
Anemia	Yes No	Emphysema/Bronchitis	Yes No	Multiple Sclerosis	Yes No
Anxiety	Yes No	Fractures	Yes No	Muscular Disease	Yes No
Arthritis	Yes No	Fibromyalgia	Yes No	Osteoporosis	Yes No
Asthma	Yes No	Gallbladder Problems	Yes No	Parkinson's	Yes No
Autoimmune Disease	Yes No	Headaches	Yes No	Pacemaker	Yes No
Bronchitis/Emphysema	Yes No	Hearing Problems	Yes No	Rheumatoid Arthritis	Yes No
Cancer	Yes No	Hepatitis	Yes No	Seizures	Yes No
Cardiac Issues	Yes No	High Blood Pressure	Yes No	Smoking	Yes No
Chem. Dependency	Yes No	High Cholesterol	Yes No	Speech Problems	Yes No
Circulation Problems	Yes No	HIV	Yes No	Stroke(s)	Yes No
Currently Pregnant	Yes No	Incontinence	Yes No	Thyroid Disease	Yes No
Depression	Yes No	Kidney Problems	Yes No	Tuberculosis	Yes No
Diabetes	Yes No	MRSA	Yes No	Vision Problems	Yes No

List all other conditions or precautions:

Where are you symptoms?



Surgical History:

Body Region: _____ Surgery Type: _____Date:_____

Body Region: _____ Surgery Type: _____Date:_____

Patient Signature: _____

I have reviewed this medical history with the named patient/caregiver prior to initiating the evaluation and treatment.

Therapist's Signature: _____Date:_____