HULST JEPSEN
PHYSICAL THERAPY

Past Medical History

Name: _____

Date of injury/onset:_____ Date of surgery (if applicable):_____ Date of next doctor appointment:_____

Briefly describe how you were injured:

_____

Please indicate if you have (or had in the past) any of the following:

	Yes	No		Yes	No		Yes	No
Diabetes			Severe Headaches			Seizures		
Chest Pain/Angina			Bowel/Bladder Abnormalities			Dizziness/Fainting		
High Blood Pressure			Urine Leakage			Fractures		
Stroke			Asthma/Breathing Difficulties			Hernia		
Heart Attack			Osteoarthritis			Ringing in your ears		
Heart Palpitations			Osteoporosis			Rheumatoid Arthritis		
Pacemaker			Pregnant			Do you smoke?		
Metal Implant			Falls in the past 6 months			Surgery (list below)		
Cancer						Physical Therapy		

If you have said yes to any of these conditions, please explain:_____

_____

____

Do you have an allergies? If yes, please list :_____

Are you allergic to latex? (circle one): YES NO

Please list any current prescription medications:_____

_____

____

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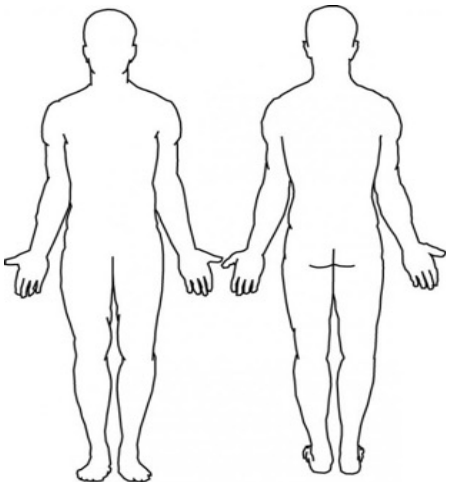
Rate the intensity of you pain/symptoms from 0-10, with 0 being no pain and 10 being the worst pain possible:

Pain Now: _____ Worst Pain: _____ Least Pain: _____

How would you rate your general health?

Good: _____ Fair: _____ Poor: _____

Please indicate the location of your pain by drawing on the body pictured.



KEY

Numbness = = = = =
Pins & Needles 0 0 0 0 0
Burning Pain XXXXXXXX
Stabbing Pain / / / / / /

Height: _____

Weight:_____