



**PAST/CURRENT MEDICAL HISTORY**

Have you ever had/been diagnosed with any of the following conditions?

- none
- cancer
- heart problems
- metal implants
- pacemaker
- heart defibrillator
- stroke
- HIV
- kidney problems
- thyroid
- epilepsy/seizure/dizziness
- Diabetes
- Arthritis
- circular/vascular problems
- infectious disease (i.e. hepatitis,tuberculosis,etc)
- list any other surgeries \_\_\_\_\_
- chemical dependency
- high blood pressure
- depression
- lung problems/ asthma
- incontinence
- blood disorder/ anemia
- multiple sclerosis
- allergies
- fractures
- stomach problems
- Parkinson's
- head injury
- spine problems/ surgery
- other \_\_\_\_\_

**PREVIOUS FUNCTIONAL LEVEL**

- Independent in all activities (work, home, recreation)

**Self Care**

- Independent (bathing, toileting, dressing, etc)
- Difficulty in performing self care activities
- Need assistance with self care activities
- Difficulty in performing household chores

**Social/Recreational/Leisure**

- Limited in \_\_\_\_\_

**WORK HISTORY**

- |                                     |   |
|-------------------------------------|---|
| <b>Employer</b> _____               | <b>Occupation</b> _____   |
| <input type="checkbox"/> full time  | <input type="checkbox"/> self <input type="checkbox"/> unemployed   |
| <input type="checkbox"/> part time  | <input type="checkbox"/> retired <input type="checkbox"/> other _____                                     |
| <input type="checkbox"/> terminated | <input type="checkbox"/> disabled <input type="checkbox"/> student; if yes please list school name: _____ |

**Physical activities at work**

- sitting  standing  computer use
- phone use  repetitive lifting  driving
- heavy equipment operation  climbing  heavy lifting
- crawling  walking  bending

**Current working status**

- full duty  restricted duty  out on leave

If not performing your normal activities at work do you plan to return to your previous activity level?  Yes  No

If you were injured on the job, please describe how the incident occurred.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

\* M.D. follow up appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed by Physical Therapist: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_