

**TAYLOR PHYSICAL & OCCUPATIONAL THERAPY**  
**PT PATIENT MEDICAL HISTORY**

New Patient     Established Patient

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Where Employed \_\_\_\_\_

Phone \_\_\_\_\_

May we contact you by email?  Yes  No    Email Address \_\_\_\_\_

Have you been treated by a physical, occupational or speech therapist, or chiropractor at any facility within this past calendar year?  Yes  No    If so, number of visits \_\_\_\_\_

Are you currently being seen by a Home Health Agency?  Name of Agency \_\_\_\_\_

Brief description of injury or illness \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date symptoms started \_\_\_\_\_

Is your injury: Work related?  Yes  No    Motor vehicle accident?  Yes  No

What are your goals for therapy? \_\_\_\_\_  
\_\_\_\_\_

Do you have or have you had any of the following?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart problems          | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Artificial joints/implants     |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Kidney disease     | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Dizziness/vertigo              |
| <input type="checkbox"/> Circulatory problems    | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Depression/mental illness      |
| <input type="checkbox"/> COPD/emphysema          | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Hearing/visual difficulties    |
| <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Rheumatic arthritis            |
| <input type="checkbox"/> Chronic ulcer           | <input type="checkbox"/> Blood clots        | <input type="checkbox"/> Other arthritic conditions     |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Back pain/sciatica | <input type="checkbox"/> Dementia                       |
| <input type="checkbox"/> History of smoking      | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Currently or possibly pregnant |

Have you fallen 2 or more times within the last year?  Yes  No

List any other medical information or special tests you've completed that you believe would be beneficial for us to be aware of \_\_\_\_\_  
\_\_\_\_\_

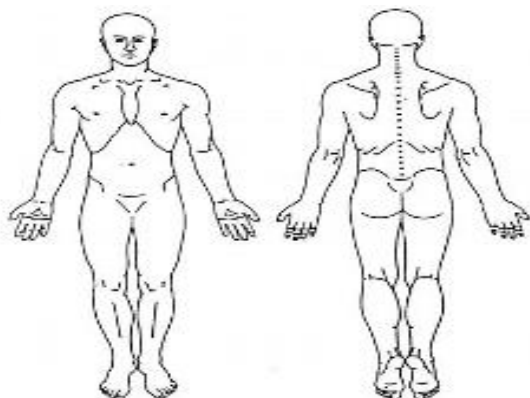
Current Medications \_\_\_\_\_  
\_\_\_\_\_

Weight \_\_\_\_\_    Height \_\_\_\_\_

**(PLEASE FILL OUT BACK PAGE)**

**PT PATIENT MEDICAL HISTORY**

Mark on the diagram below where you currently are experiencing symptoms:



**Mark below the intensity of your symptoms.**

*Please circle the appropriate number (0=no symptoms; 10=worst possible symptoms)*

Currently: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

**How restricted are your normal activities?**

*(0 = No Limitations; 10 = Totally Disabled)*

0 1 2 3 4 5 6 7 8 9 10

**Work capabilities since your injury:**

- No Work Limitations
- Some Work Limitations
- Unable to Work
- N/A (Child, Student, Retiree, Disabled)

How often do you have these symptoms?  
*(Please check one below)*

Constantly (24 hours/day)

Frequently (12-23 hours/day)

Occasionally (6-12 hours/day)

Not Frequently (0-6 hours/day)

Please list other treatment you have received for this condition \_\_\_\_\_

How did you hear about Taylor Therapy? \_\_\_\_\_

**INFORMED CONSENT**

I hereby authorize treatment to be administered after evaluation according to the therapist's discretion. This may include, but not limited to, spinal or joint traction, ultrasound, electrical muscle stimulation, whirlpool or aquatic therapy, iontophoresis, manual therapy, instrument assisted soft tissue mobilization, and exercises. I understand that the necessary procedures to be provided will be explained along with the risks and benefits. We utilize a therapy dog in our clinic so please let us know if you have a known allergy.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_