

PALMER PHYSICAL THERAPY for WOMEN
10333 E. 21st Street N. Suite 406 Wichita, KS 67206 316.630.9944

PATIENT MEDICAL HISTORY FORM

Date: ____/____/____

Name: _____ Age: _____ Height: _____ Weight: _____ (Confirmed: _____)

Referring Physician: _____ Next appt. with physician: _____

Occupation/Type of Work: _____ Hours per week: _____

How did you find out about us? TV Radio Billboard Website Doctor Other _____

Medical History:

Number of Pregnancies _____ Number of vaginal deliveries _____ Number of c-sections _____
 Hysterectomy Neck/Back Surgery Heart Disease High Blood Pressure Diabetes Osteoporosis/Osteopenia
 Lung/Breathing Problems Arthritis Cancer Recent Unexplained Weight Loss Current treatment to suppress immune system Pelvic Pain Urinary Incontinence Pacemaker Seizures Allergies Metal Implants
 Stroke/CVA Kidney Problems Fractures Recent Accident (if yes, explain) _____
 Intolerance to Heat or Cold Skin Problems Other _____
Do you smoke? Yes No Has your physician limited your activity? Yes No (If yes, explain _____)

Do you have a fear of falling? Yes No Have you fallen in the past year? Yes No (If Yes, how many falls? _____)
Were you injured in a fall in the past year? Yes No (If yes, explain _____)

Current Medication list: Please bring a copy with you to your appointment (PT received/reviewed Yes No)

When did the problem(s) begin? (Date of Injury/onset) _____
Are your symptoms getting worse? Yes No

Please rate your pain level from 0 to 10

0=no pain, 1=very mild, 2=discomforting, 3=tolerable, 4=distressing, 5=very distressing, 6=intense, 7=very intense, 8=utterly horrible, 9=excruciating, 10= will go unconscious shortly

_____ at worst _____ at best _____ on average _____ current

Does your pain radiate into your arm or leg? Yes No

If so, how far down does the pain travel? _____

Do you have numbness or tingling? Yes No

If so, where? _____

What makes your pain worse? _____

What decreases your pain? _____

Have you had these symptoms before? Yes No

Have you had prior treatment for this problem? Yes No If Yes, explain: _____

Do you leak urine? Yes No

How often do you urinate during the day? _____

Do you have painful intercourse or have pain with the use of a tampon? Yes No

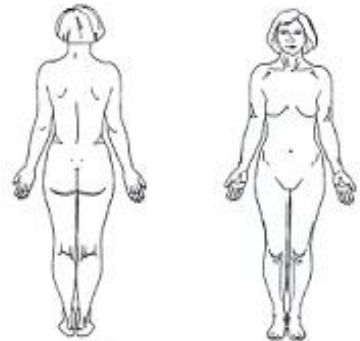
Are you pregnant? Yes No If so, how many weeks? _____

Briefly describe any additional problem(s) you are having: _____

Do you participate in sports, hobbies, exercise programs, or activities? _____

Additional Comments: _____

Please Mark Location Of Your Pain



KEY: Numbness =====
Pins/Needles 000000
Burning Pain XXXX
Stabbing Pain /////