

PALMER PHYSICAL THERAPY for WOMEN
2020 N. Webb Suite 104 Wichita, KS 67206 316.630.9944

PATIENT MEDICAL HISTORY FORM

Name: _____ Age: _____ Date: ____/____/____

SS#: _____ Referring Physician: _____

Occupation: _____ Next appt with physician: _____

Medical History:

- Hysterectomy Neck/Back Surgery Heart Disease High Blood Pressure Diabetes Osteoporosis
- Lung/Breathing Problems Arthritis Cancer Pelvic Pain Urinary Incontinence Pacemaker Seizures
- Allergies Metal Implants Stroke/CVA Kidney Problems Fractures Intolerance to Heat or Cold
- Skin Problems Other _____

Current Medications: _____

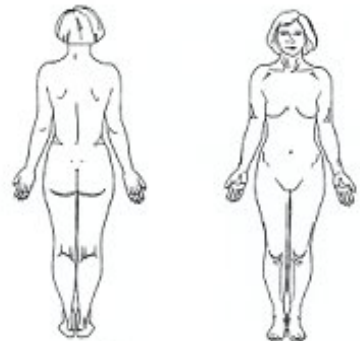
Briefly describe the problem(s) you are having: _____

When did the problem(s) begin? (Date of Injury/onset) _____

Please rate your pain level with these activities from 0 to 10
(0 = no pain, 10 = unbearable pain)

____sitting ____standing ____lying down ____bending
____walking ____at rest ____at worst

Please Mark Location Of Your Pain



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 decreases your pain? _____

Have you had these symptoms before? Yes No

Have you had prior treatment for this problem? Yes No

KEY: Numbness =====

Pins/Needles 000000

Burning Pain XXXX

Stabbing Pain /////

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? _____

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

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

Additional Comments: _____
