Michigan Therapeutic Solutions, Inc

Medical History

Patient Name:______________________________________ Date of Birth:_________________________

Address:____ Social Security Number:_________________

____ Phone Number:______________________

1. Have you ever been diagnosed or currently have the following conditions? (Please check)

___ Heart Disease
___ Tuberculosis
___ Asthma
___ High Blood Pressure
___ Allergies
___ Osteoarthritis
___ Diabetes
___ Headaches
___ Anxiety
___ Dizzy / Fainting Spells
___ Hepatitis B
___ Kidney Problems
___ Epilepsy / Seizures
___ Multiple Sclerosis
___ Stroke
___ Head / Neck Injury
___ Rheumatoid Arthritis
___ Stomach / GI Problems
___ Blood Disorder
___ Parkinson's Disease
___ Osteoporosis
___ Respiratory Problems
___ Hernia
___ Circulatory Disorder
___ HIV / AIDS
___ Peripheral Neuropathy
___ Chest Pain / Angina
___ Fractures
Location(s): _______________
___ Cancer
Location(s): _____________
___ Rheumatic Fever
___ Congenital disorder
Other: ____

2. Please list any prior / recent surgeries: ____
____
____

3. Are you currently pregnant? Yes / No / NA

4. Are you currently taking any medications? If yes, please provide a list of names
____
____

5. Please rate your current pain by circling the number that best represents it

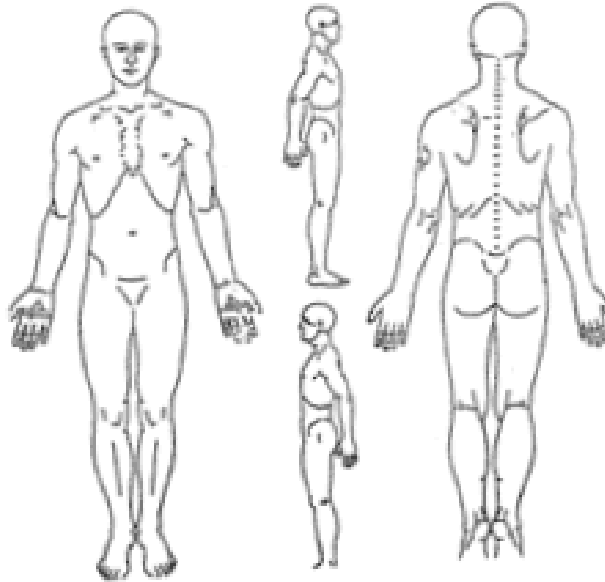
0 1 2 3 4 5 6 7 8 9 10
No Pain Severe

6. In the past 6-12 months, have you felt sad, depressed or lost interest in doing things? YES / NO

7. Do you have any: Pacemaker YES / NO Metal Implants YES / NO Stents YES / NO

8. Please indicate, on this diagram, the location of your pain, numbness or tingling is occurring.

XXX = Pain
ooo = Numbness
––– = Tingling
/// = Burning



9. Since onset, are your symptoms getting: ☐ Better ☐ Worse ☐ Not changing

10. What type of pain are you experiencing?

☐ Throbbing ☐ Sharp ☐ Aching ☐ Tingling ☐ Burning ☐ Numbness

☐ Shooting ☐ Dull ☐ Constant ☐ Occasional

11. As the day progresses, do your symptoms:

☐ Increase ☐ Decrease ☐ Stay the same

12. Which activities increase your symptoms? ______________________________

____

13. What do you do to relieve your symptoms? ______________________________

____

14. Have you had any treatment for this condition in the past? ☐ Yes ☐ No
Please list all: ______________________________

15. Have you received any of the following tests for this problem?

☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐ ECG ☐ Other

16. What are your goals and expectations for physical therapy? ______________________________

____

17. Do you participate or like to participate in leisure / recreational activities? List: ______________________________

____

Patient Signature:______________________________ Date: ______________

Therapist Signature:______________________________ Date: ______________