Marquis Physical Therapy & Spine Rehab, P.C.
Medical History

Name:_____ Dominant Hand: □ Right □ Left
Are you currently being treated for any other problems other than what brings you here today? _____ YES _____ NO If yes, explain: _____
Occupation: _____
□ Full Time □ Part time □ Light Duty □Unemployed □ Retired □ Student □Disabled

Check the following medical conditions that apply **to you**:

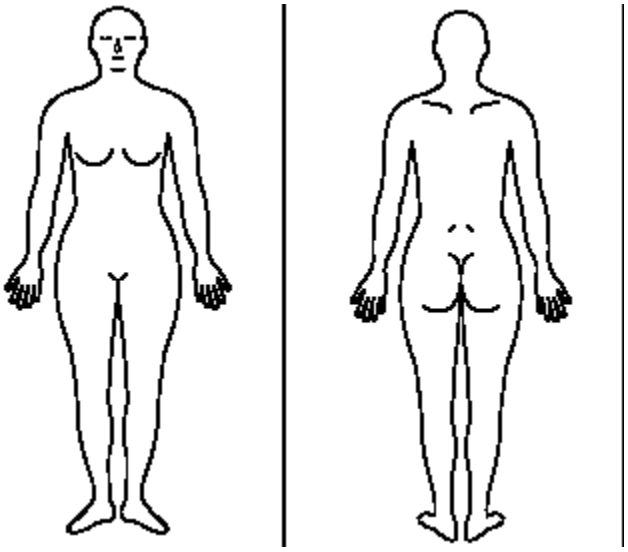
□Arthritis	□Diabetes	□Allergies
□Heart Problems	□allergies to local anesthetics	□Headaches
□Joint Replacements	□Difficulty Sleeping	□Dizziness
□High Blood Pressure	□Osteoprosis	□Pacemaker
□Circulatory Problems	□Recent weight changes	□Pregnancy
□Breathing problems	□Visual problems	□Nausea
□Difficulty walking	□Hearing problems	□Seizures
□Hernia	□Difficulty urinating	□Fibromyalgia

□History of Cancer? If so, where? _____
□History of Surgery? If so, where? _____

Prescription Medications: _____
History of the current problem:
When did the problem(s) begin? _____
What happened? _____
Have you had the problem(s) before? □ YES □ NO
What makes the problem(s) worse? _____
What makes the problem(s) better? _____
Draw on the body diagram below exactly where your symptoms (pain, etc) is located:

Please rate your pain based On this scale:
0-No pain
1-Very weak
2-Weak
3-Moderate
4-Somewhat strong
5-Strong
6-
7-Very strong
8-
9-Very, very strong
10-Emergency

NOW:_____
Last 30 days:_____



I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Patient Signature	**Date**
Reviewed by Therapist	