PHYSICAL THERAPY CENTER
Of Rocky Hill

Medical History Form

Personal Details

Name: _____ Date of Birth: _____

Email Address: _____ Date Symptoms Started: _____

Height: _____ ft _____ in Weight: _____ lbs.

Emergency Contact: _____ Phone: _____

How did you hear about this clinic? _____

Health Care Details

Referring MD: _____ Primary Care MD: _____

Do you have a pacemaker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Have you recently received Home Care services? ☐ Yes ☐ No

Agency? _____ End Date: _____

Medical Details

Are you currently taking any medications? ☐ Yes ☐ No (If Yes, please list on the attached sheet)

Allergies: _____

Do you have, or have you had, any of the following (if yes, please explain):

☐ Yes ☐ No Arthritis _____

☐ Yes ☐ No Cancer_____

☐ Yes ☐ No Cardiac Problems (Heart Attack, High Blood Pressure) _____

☐ Yes ☐ No Neurological Problems (Stroke, Seizure, Headaches, Numbness) _____

☐ Yes ☐ No Circulatory Problems (Thrombosis, DVT, PVD, PAD, Anemia, Raynaud's) _____

☐ Yes ☐ No Osteoporosis/Osteopenia_____

☐ Yes ☐ No Balance Problems_____

☐ Yes ☐ No Diabetes_____

☐ Yes ☐ No Depression or Anxiety_____

☐ Yes ☐ No Any Artificial Implants _____

☐ Yes ☐ No Latex Allergy _____

☐ Yes ☐ No Fever/Night Sweats/Unexplained Weight Loss or Gain_____

☐ Yes ☐ No Any other condition(s)_____

☐ Yes ☐ No Have you had two or more falls in the past year? _____

☐ Yes ☐ No Have you had any falls with injury in the last year? _____

If you are having pain, please rate your pain on a 0-10 scale:

At its **WORST**: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Current pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

At its **BEST**: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)