FORGED ATHLETE

Medical History Form

Patient Name:	DOB:	Date:
Type of Injury/Condition you are here for:	Onset/Injury Date:	
Email:	Phone:	
Parent/Guardian Name (if you are a minor):	Emergency Contact Name: Relationship: Phone:	
How did you find out about us?	Did anyone refer you to us?	

What do you hope to accomplish with PT?:
Please list specific activities you have difficulty with or are unable to perform due to your condition • • •
Any previous treatment/surgery for this condition:
Indicate any tests you have had: X-Ray MRI EMG CT Scan Ultrasound

Have you recently noticed:		
❏ Unexpected weight loss/ gain	❏ Numbness/ Tingling	❏ Changes in Bowel/Bladder Habits
❏ Nausea	❏ Fainting	❏ Change in Vision or Double Vision
❏ Vomiting	❏ Pain at Night	❏ Numbness/Tingling in Groin Area
❏ Dizziness	❏ Difficulty Swallowing	❏ Numbness/Tingling in hands and feet at the same time
❏ Extreme Fatigue	❏ Difficulty Speaking	
❏ Unexplained Weakness	❏ Stumbling While Walking	
	❏ Pain with coughing/sneezing	

Do you have now, or have you ever had any of the following? ❏ Surgeries ❏ Sprains/Strains ❏ Fractures ❏ Loss of Consciousness ❏ Pregnancy	❏ Diabetes ❏ Blood Pressure Problems ❏ Heart Problems ❏ Cancer ❏ Motor Vehicle Accident ❏ Circulation Problems/ Blood Clots	❏ Asthma/ Breathing Problems ❏ Osteoporosis/ Osteopenia ❏ Easy Bruising/ Bleeding ❏ Indigestion/ Heartburn ❏ Allergies/ Skin Sensitivity
What makes you pain better?: What makes your pain worse?:		

Are you currently taking any medications? ❏ Yes ❏ No	Name type(s) of medication:
Type(s) of Pain: ❏ Sharp ❏ Burning ❏ Aching ❏ Stiffness/tightness ❏ Throbbing	❏ Tingling ❏ Numbness ❏ Dull ❏ Constant ❏ Intermittent ❏ Other

Since your symptoms began, do you have difficulty with anything listed here?: ❏ Sleep ❏ Diet ❏ Stress ❏ Standing ❏ Sitting ❏ Getting up from a chair ❏ Walking ❏ Bending ❏ Squatting	❏ Jumping ❏ Running ❏ Lying down ❏ Self care ❏ Reaching ❏ Pushing/pulling ❏ Work related activities ❏ Stairs ❏ Sports or wellness related activities ❏ Lifting/carrying

Current Medications/Supplements:_____

Average hours of sleep per night:_____

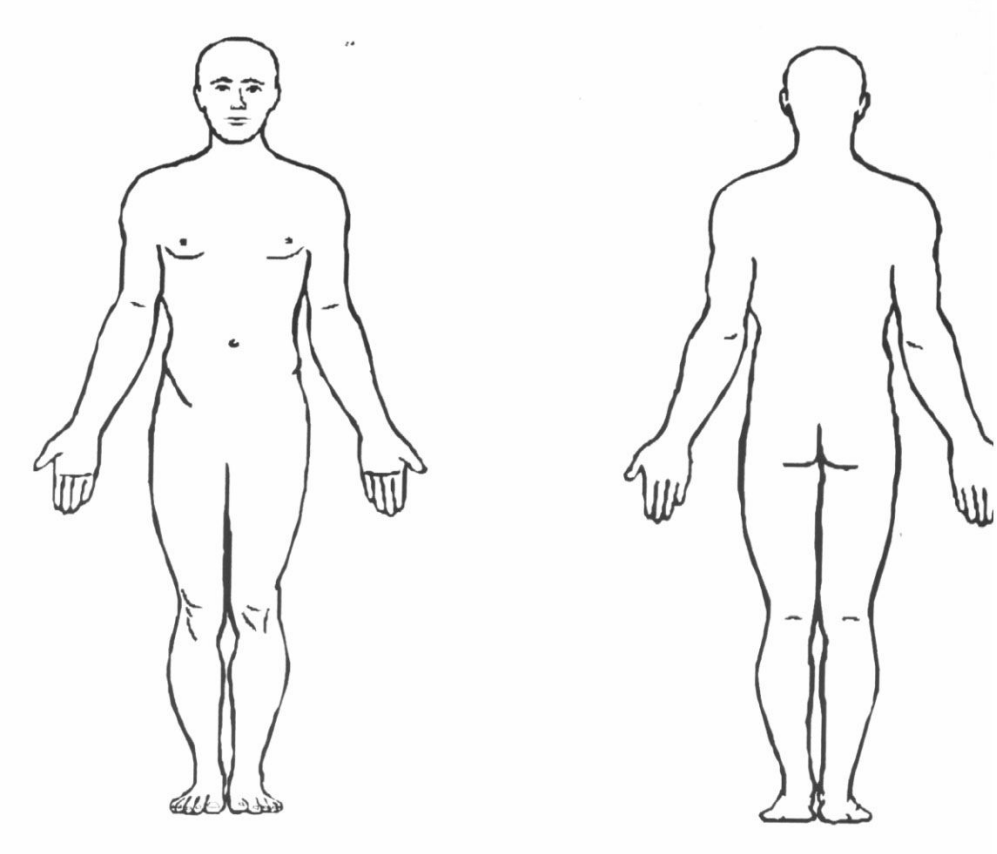
General stress level?_____

Dietary habits:_____

Do you smoke?_____

Any history of falls?_____

Please indicate the location of your primary complaint(s):



Print Name:_____

Signature:_____

Date:_____