

# Mid-Nebraska Physical Therapy & Sports Center

## Patient Medical History & Physical Condition

Answer to following questions will assist the therapist in providing a safe and effective treatment program.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

Date of Next Appointment: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

PROBLEM TO BE TREATED: \_\_\_\_\_

Is condition accident related? Yes / No If yes, was it: WORK / AUTO / OTHER \_\_\_\_\_

Have you been treated for this problem before? YES NO  
If yes, state specifics \_\_\_\_\_

Have you had surgery? YES NO  
Please list date and type \_\_\_\_\_

Other major illness or surgery in the past year? \_\_\_\_\_

Are you currently taking medications? YES NO  
Please list \_\_\_\_\_

Family Physician: \_\_\_\_\_

Have you had any of the following at any time?

High Blood Pressure	Y	N	Sensitivity to Heat or Ice	Y	N
Heart Disease	Y	N	Allergies	Y	N
Pacemaker	Y	N	Diabetes	Y	N
Seizures	Y	N	Metal Implants	Y	N
Balance Problems	Y	N	Plastic Implants	Y	N
Vision Problems	Y	N			

Please explain and give approx. date \_\_\_\_\_

Please list any other medical conditions that would interfere with treatment \_\_\_\_\_

The above information is correct to the best of my knowledge.

Patient \_\_\_\_\_ Date: \_\_\_\_\_

Therapist \_\_\_\_\_ Date: \_\_\_\_\_