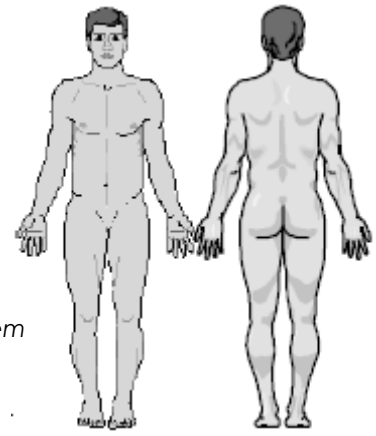
KINETIC EDGE PHYSICAL THERAPY

MEDICAL HISTORY FORM

Date:		Name:		Age:
Height:		Weight:		BMI:

ABOUT YOUR CURRENT COMPLAINT:

1. What is the complaint that brought you here? _____
2. What caused this complaint? _____
3. When did this complaint begin or recently become worse? Approximate Date: _____
4. What are your chief complaints (check all that apply):
   - ☐ Weakness ☐ Swelling ☐ Pain: draw on body
   - ☐ Loss of Motion ☐ Loss of Function ☐ Other: _____
5. Does this complaint cause issues with your sleep? (check all that apply)
   - ☐ Difficulty falling asleep ☐ Awakened by pain
   - ☐ Difficulty finding comfortable position ☐ Other:



6. How would you rate your ability to perform routine daily activities? (circle one)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Unable *No Problem*

7. What is your work status?
   - ☐ Full time ☐ Light Duty ☐ Not working ☐ Retired
   - ☐ Part time ☐ Modified Duty ☐ Homemaker ☐ Student
8. Rate your symptom intensity in the past 5 days (0 is no pain or symptoms and 10 is the worst possible pain or symptoms):
   - Symptoms at their worst: 0 1 2 3 4 5 6 7 8 9 10
   - Symptoms at their best: 0 1 2 3 4 5 6 7 8 9 10
9. Have you had any surgeries for this condition? ☐ Yes ☐ No Date of surgery: _____ Type of surgery: _____
10. What tests have you had for this complaint? (check all that apply)
    ☐ None ☐ X-Ray ☐ CAT Scan ☐ MRI ☐ Myelogram ☐ Bone Scan Results of tests: _____
11. Is this complaint work related? ☐ Yes ☐ No Last date worked: _____ Your occupation: _____
12. Is this complaint auto related? ☐ Yes ☐ No
13. Is this injury in litigation with an attorney? ☐ Yes ☐ No Name of attorney: _____
14. Have you seen any other medical provider for this specific condition or injury? _____

ABOUT YOUR GENERAL HEALTH:

1. Please check all medical conditions that you <u>have</u> or <u>have had</u>:

☐ Cancer	☐ Joint Replacements	☐ Headaches	☐ Osteoporosis
☐ Diabetes	☐ Metal Implants	☐ Pacemaker	☐ Epilepsy
☐ Heart Condition	☐ Syncope/ Fainting	☐ Asthma	☐ Shortness of Breath
☐ High Blood Pressure	☐ Osteoarthritis	☐ Allergies	☐ Malaise/ Fatigue
☐ Nausea/ Vomiting	☐ Bowel Dysfunction	☐ Dizziness	☐ Tobacco/Nicotine-use
☐ Rheumatoid arthritis	☐ Weight Change	☐ Pregnant	☐ High Cholesterol
☐ Depression/anxiety:	☐ Other:		

2. Please list other surgeries: _____
3. Please list allergies: _____
4. Please list medications you are taking: _____

ADDITIONAL INFORMATION:

1. What are your goals with PT/OT treatment? _____
2. Are you interested in learning about our Medical Fitness program? ☐ Yes ☐ No ☐ Maybe
3. How did you find out about Kinetic Edge?
   - ☐ Printed Ad ☐ Website ☐ Social Media ☐ Google ☐ Physician ☐ Returning Client ☐ Workshop ☐ Radio
   - ☐ Walk In ☐ High School Athlete ☐ Employer ☐ From friend/family member: _____
   - ☐ Kinetic Edge Team Member: _____ ☐ Other: _____

Patient Signature: _____ Date: _____

KINETIC EDGE
PHYSICAL THERAPY

*****For office use only:**

Name: _____ **Date:** _____ **DOI/DOS:** _____

Region: _____ **Frequency/ Duration:** ____X____ **Work Status:** F L O M

Affected Side: _____ Right ____ Left ____ Dominant ___Non-Dom

Diagnosis codes: _____ _____ _____ _____ _____ **Surgical Status:** ____ Surgical ___Non-Surgical ___Pre-Surgical

Care Connections Medical Condition Reporting: ____ Total Knee ____ ACL reconstruction ___ Total Hip ___ Total Shoulder
___ Rotator cuff repair – incomplete tear ___ Rotator Cuff repair – complete tear ____Rotator cuff injury

Reasons for therapy:
___ Atrophy ___ Muscle Weakness (generalized) ____ Pain ____ Stiffness ____ Swelling/Edema _____Gait ____ Coordination

COMORBIDITIES:
_____ None _____ Maladaptive Pain Response _____Multiple Treatment Areas

GOALS:

_____ HEP	_____ Work full duty without restrictions	_____ Pain goals
_____ Able to run	_____ Improve UE ROM	_____ Improve Cervical ROM
_____ Return to sports/ fitness	_____ Improve LE ROM	_____ Improve Shld Strength
_____ Improve core strength	_____ Improve L ROM	_____ Improve Shld ROM
_____ Improve UE strength	_____ Normalize LS ROM	_____ Decrease HA's
_____ Improve LE strength	_____ Return to prev level of function	

_____ _____

_____ _____

_____ _____

PLAN:
_____ Ther Act _____ Patient Ed _____ Ther Ex _____ Manual Therapy _____ Modalities PRN _____ Neuro Re-ed _____ Gait Trng

Provider Notes: