JOHNSTON PHYSICAL THERAPY
& SPORTS MEDICINE
Orthopedic, Industrial & Sports Rehabilitation Services
PATIENT MEDICAL HISTORY

NAME: _____

MAIN COMPLAINT: _____

How did you hear about Johnston Physical Therapy? *(Please check appropriate box)*

☐ Physician ☐ In-Network Provider List ☐ Location ☐ Friend ☐ Advertisement ☐ Other_____

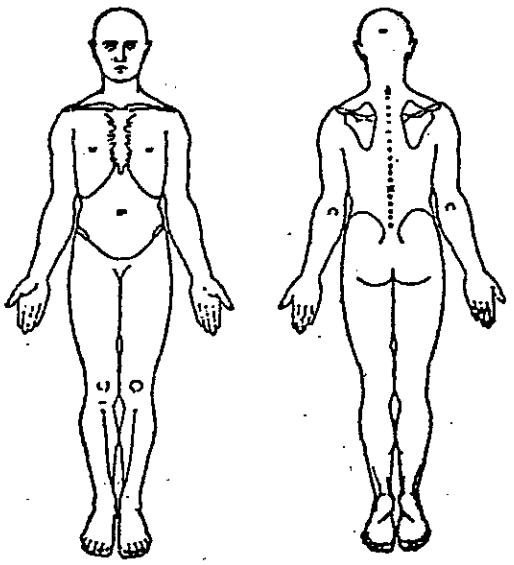
PAIN RATING: ***0-10 WITH "0" AS NO PAIN AND "10" REQUIRING IMMEDIATE MEDICAL CARE***

***Please circle your **current** pain level*
0 1 2 3 4 5 6 7 8 9 10

***Please circle your **peak** pain level*
0 1 2 3 4 5 6 7 8 9 10

***Please circle your **minimal** pain level*
0 1 2 3 4 5 6 7 8 9 10

Mark on the diagram to the right the location of your pain by shading in the area.



MEDICATIONS (*Please list reason why taking*): _____

_____

_____

_____

PAST MEDICAL HISTORY: (PLEASE CHECK APPROPRIATE BOXES *If have or have ever had*)

- ☐ Hypo/Hypertension (Low/High Blood Pressure)
- ☐ Diabetes
- ☐ Cancer(*specify type*) _____
- ☐ Irregular Heart Beat
- ☐ Other Heart Conditions(*specify*)_____
- ☐ Osteoporosis
- ☐ Rheumatoid/Osteo Arthritis
- ☐ Pregnancy *(current)* # of weeks_____
- ☐ Seizures
- ☐ Hyper/Hypo Thyroidism
- ☐ Asthma

PREVIOUS SURGERIES or HOSPITALIZATIONS: *(Please list surgery and date of surgery)*

_____

_____

_____

_____