Canyon Sports Therapy
PHYSICAL THERAPY & SPORTS BIOMECHANICS

MEDICAL HISTORY SURVEY

Your medical history and health background are critical to our evaluation and management of your condition. We will consider the information provided on this form to tailor a treatment plan that meets your unique needs and streamlines our facilitation of your goals.

NAME:_____ OCCUPATION:_____

LEISURE ACTIVITIES: _____

REASON FOR THERAPY: (CIRCLE ONE) *HOME RELATED* *WORK RELATED* *AUTO RELATED* *OTHER*

EXPLAIN INJURY OR PROBLEM: _____

_____

DATE OF INJURY 0R FIRST SYMPTOMS:_____ DATE OF SURGERY: _____

TYPE OF SURGERY: _____

REFERRING DOCTOR: _____ DIAGNOSIS: _____

DATE OF LAST DOCTOR VISIT: _____ DATE OF NEXT DOCTOR VISIT: _____

PLEASE LIST RECENT DIAGNOSTICS STUDIES AND DATES (X-RAYS, MRI, CT SCAN, ETC.) OR ANY PREVIOUS TREATMENTS:

_____

DO YOU HAVE ANY RESTRICTIONS OR PRECAUTIONS TO FOLLOW?:_____

_____

CURRENT MEDICATIONS (including over-the-counter drugs & herbal remedies):_____

_____

ALLERGIES:_____

_____ ARE YOU BEE'S WAX OR LATEX-SENSITIVE?_____

HAVE YOU EVER BEEN DIAGNOSED WITH:

YES NO ANEMIA
YES NO ARTHRITIS If yes, what type?_____
YES NO ASTHMA
YES NO CANCER If yes, what type?_____
YES NO CIRCULATION PROBLEMS
YES NO CHEMICAL DEPENDENCY (alcohol, drugs, medications)
YES NO DEPRESSION
YES NO DIABETES
YES NO EPILEPSY
YES NO GASTROINTESTINAL PROBLEMS
YES NO HEART PROBLEMS
YES NO HEPATITIS
YES NO HIGH BLOOD PRESSURE
YES NO HIV/AIDS
YES NO KIDNEY DISEASE
YES NO OSTEOPOROSIS
YES NO OSTEOPENIA
YES NO STROKE
YES NO THYROID PROBLEMS
YES NO TUBERCULOSIS

ANY MAJOR MEDICAL PROBLEM NOT LISTED:_____

(CONTINUED ON THE BACK)

LIST ANY MAJOR INJURIES OR SURGERIES & APPROXIMATE DATES OF OCCURRENCE (i.e. dislocations, fractures, etc.):

_____

_____

_____

_____

_____

_____

_____

WHEN IS YOUR DISCOMFORT WORST (morning, midday, evening, bedtime)?_____ _____

WHAT ALLEVIATES YOUR DISCOMFORT?_____

_____

WHAT AGGRAVATES YOUR DISCOMFORT?_____

_____

WHAT FUNTIONAL LIMITATIONS ARE YOU EXPERIENCING? (i.e. working, driving, caring for yourself/others, etc.):

_____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING?

YES NO NAUSEA/VOMITING
YES NO FATIGUE
YES NO FEVER/CHILLS
YES NO WEIGHT LOSS/GAIN
YES NO WEAKNESS
YES NO TINGLING/NUMBNESS

HAVE YOU FELT DOWN OR LOST INTEREST IN THINGS YOU LIKE TO DO?_____

HOW FREQUENTLY DO YOU….

SMOKE CIGARETTES? _____ times daily/weekly (circle one)

ARE YOU CURRENTLY EXERCISING? *YES / NO* WHAT TYPE OF EXERCISE?_____

WHAT ARE YOUR EXPECTATIONS FROM PHYSICAL THERAPY?_____

_____

WHAT ARE YOUR LONG-TERM HEALTH AND/OR ATHLETIC GOALS?_____

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?_____

_____

WE LOOK FORWARD TO WORKING WITH YOU –
THANKS FOR TAKING THE TIME TO SHARE YOUR HISTORY!