

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

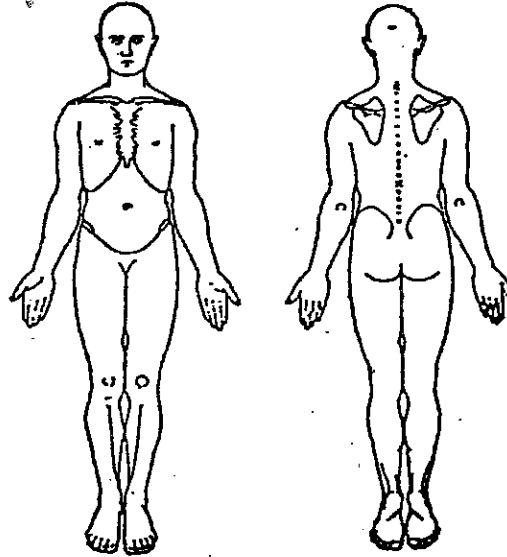
**Please circle your peak pain level

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)