Van Buren County Hospital
*Simply Remarkable*

An Affiliate of MERCYONE

## Patient Medical History

Name _____ DOB _____ Occupation _____

Have you had Physical Therapy in the Current Calendar Year? Yes☐ No☐

Past Surgery/Injuries:

_____

X-rays, MRI, CT Scan results:

_____

Medications: _____

Allergies: _____

Do you or have you had any of the following?

Hypertension ☐ Diabetes ☐ Kidney Disease ☐

Thyroid Issues ☐ Stroke ☐ Lung Disease ☐

Liver Disease ☐ Cancer ☐ Pacemaker ☐

Heart Trouble ☐ Mental Illness ☐

Caffeine: ☐Daily ☐Rarely ☐Never #of cups /day: _____
Alcohol: ☐Daily ☐Rarely ☐Never Amount per day: _____
Tobacco: ☐Daily ☐Rarely ☐Never Frequency/week: _____

What are your goals with Physical Therapy?

_____

How has this injury/pain influenced your ability to do your daily activities?

_____

On a scale of 0-10, with 10 being the worst pain you can imagine, how would you rate your pain?

At its best_____ At its worst____ At this time____

Patient Signature