NEW PATIENT FORMS

Medical History & Systems Review

C.O.R.E. PHYSICAL THERAPY
Center for Orthopedic Rehab and Exercise

Medical History for _____
Patient Name (please print)

	YES	NO
Are you in generally good health?	☐	☐
Have you had recent surgery or hospitalization? If so, please specify; _____	☐	☐
Are you currently taking any medications? Please include Over-the-Counter medications and Vitamins.	☐	☐
_____		
_____		
Have you had recent tests such as x-ray, MRI, Scans? _____	☐	☐
Have you ever taken steroids (i.e. cortisone, prednisone)?	☐	☐
Are you currently seeing any of the following?		
Medical Doctor	☐	☐
Osteopath	☐	☐
Psychiatrist/Psychologist	☐	☐
Chiropractor	☐	☐
Do you have or have you ever been diagnosed as having any of the following:		
Cancer: kind: _____	☐	☐
Heart Problems	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Chemical Dependency (e.g. alcoholism)	☐	☐
Thyroid problems	☐	☐
Diabetes	☐	☐
Multiple Sclerosis	☐	☐
Rheumatoid Arthritis	☐	☐
Other Arthritic Conditions	☐	☐
Depression	☐	☐
Hepatitis	☐	☐
Tuberculosis	☐	☐
Stroke	☐	☐
Kidney Disease	☐	☐
Anemia	☐	☐
Epilepsy	☐	☐
Other _____	☐	☐
Are you pregnant?	☐	☐
Have you recently lost or gained more than 10 pounds?	☐	☐
Are you experiencing any bowel/bladder irregularity?	☐	☐
Do you experience any numbness/tingling in your buttock or genital region?	☐	☐
Do you have any numbness/tingling in BOTH hands or feet at the same time?	☐	☐
Do you experience any weakness in your legs or balance problems during walking?	☐	☐
Do you have any dizziness related to moving your head or neck?	☐	☐
Do you experience blurred vision, nausea, or difficultly breathing?	☐	☐

How would you rate your stress level? _____

How much caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke per day? _____

How many days per week do you drink alcohol? _____