Hillcrest
PHYSICAL THERAPY & WELLNESS
Optimum Results, Healthy Living

Client Medical History

Today's Date _____

Name _____
Last First M.I.

Address _____
Street City State ZIP

_____ _____ _____
Date of Birth Social Security Number Email Address

_____ _____ _____
Home Phone Cell Phone Work Phone

Phone preference for appointment reminders (check one): ___Home ___Cell ___Work
Text message reminders for appointments? ___Yes ___No
Email reminders for appointments? ___Yes ___No

_____ _____ _____
Referring Physician Physician's Phone Next Appointment Date

Insurance Information: Please bring **all** of your current insurance cards and your ID to your appointment.

Chief Complaint: _____
Date of Injury/Onset: _____
How did this injury/exacerbation occur? _____
_____
Have you ever been hospitalized for this condition? ___YES ___NO If Yes, date? _____
Have you had surgery for the present condition? ___YES ___NO If Yes, date? _____
If yes, surgery type? _____
Please list any additional surgeries or other conditions for which you have been hospitalized, including dates: _____
_____
_____
_____

Have you received previous treatment for this condition? (Please check all that apply)

____ Chiropractor	____ Occupational Therapy
____ CT Scan	____ Oncologist
____ Emergency Room Care	____ Orthopaedist
____ EMG/NCV	____ Physical Therapy
____ General Practitioner	____ Podiatrist
____ Massage Therapy	____ Speech Therapy
____ MRI	____ X-rays
____ Neurologist	____ Other

4215 University Drive, Suite B2
Durham, NC 27707

Phone 919-627-6700
Fax 919-627-6627

Results from these treatments, if known:_____

_____

_____

_____

Have you had any falls within the past year? ___YES ___NO
If so, how many?_____ Any injuries resulting from the fall(s)?

_____

_____

_____

_____

Do you smoke? ___YES ___NO

Do you now or have you ever had any of the following? (Please check all that apply)

_____ ALS
_____ Alzheimer's disease
_____ Anemia
_____ Asthma, Bronchitis, or Emphysema
_____ Blood Clot/Emboli
_____ Bowel or Bladder Problems
_____ Brain Injury
_____ Cancer
_____ Chemotherapy/Radiation
_____ Congestive Heart Failure
_____ COPD
_____ Coronary Heart Disease or Angina
_____ Defibrillator
_____ Dementia
_____ Diabetes
_____ Dizziness or Fainting
_____ Drug/Alcohol Dependency
_____ Emotional/Psychological Problems
_____ Epilepsy/Seizures
_____ Fibromyalgia
_____ Gastric Reflux
_____ Glaucoma
_____ Gout
_____ Heart Attack or Surgery
_____ Hepatitis
_____ Hernia
_____ High Blood Pressure
_____ HIV/AIDS
_____ Infectious Disease
_____ Joint Replacement
_____ Kidney Disease
_____ Lupus
_____ Lymphedema
_____ Multiple Sclerosis (MS)
_____ Nursing/Breastfeeding
_____ Osteoporosis
_____ Pacemaker
_____ Parkinson's Disease
_____ Pregnancy
_____ Psoriasis
_____ Rheumatoid Arthritis
_____ Severe or Frequent Headaches
_____ Shortness of Breath/Chest Pain
_____ Sleeping Problems/Difficulties
_____ Spinal Cord Injury
_____ Stroke/TIA
_____ Thyroid Trouble/Goiter
_____ Unexplained Weight Loss
_____ Vision or Hearing Difficulties

Please list all current medications including prescriptions, over-the-counter, herbals, supplements. Please include dosages for all medications.

Allergies: _____

Are you latex sensitive? ___YES ___NO

Do you have any braces, ankle foot orthoses (AFOs), orthotics, or prosthetic devices? ___YES ___NO
If yes, how often do you wear these devices?_____

Occupation or Primary Job Demands (for example, prolonged sitting/standing, computer work, lifting, pulling, etc.)_____

Job Status (Please check one)

_____ Working full time, regular duty
_____ Working restricted hours, regular duty
_____ Out of work secondary to injury
_____ Working full time, light duty
_____ Working restricted hours, light duty
_____ Unemployed
_____ Retired

My personal goal(s) from physical therapy treatment are:_____

Regarding the injury for which you are seeing us today, please rate your pain level:

Pain at **LOWEST**: Rate your **lowest** pain **IN THE PAST 3 DAYS.**

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

Pain **CURRENTLY**: Rate your level of pain **NOW.**

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

Pain at **WORST**: Rate your **highest** pain level **IN THE PAST 3 DAYS.**

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain

In case of an emergency, whom should we contact?

Name

Relationship

Home Phone Cell Phone Work Phone