Brunswick Physical Therapy, PLLC.
Medical History

Patient Name:			Date:
Prescription Medications			
Name of Medication	**Dosage Ex (mg, cc)**	**Frequency Ex (2 x Daily)**	**More Info if needed**
Surgery Dates (Past & Present)	**Body Part**	**Allergies**	**Reaction**

Place an "X" if you have experienced or been told that you have any of the following:					
Asthma		Kidney Disease		Fainting	
Emphysema		Hepatitis/Jaundice		Migraine/Headaches	
Chest Pain		Bowel/Bladder Problems		Osteoporosis	
Heart Disease		Blood Disorder		Cancer	
Stroke		Pregnancy		Visual Loss	
Dizziness		Shortness of Breath		Hearing Loss	
Epilepsy/Seizures		High Blood Pressure		Chemical Dependency	
Arthritis		Blood Clot		Depression	
Diabetes		Head Injury/Concussion		Anxiety	
Fibromyalgia		Any Neurological Diseases		Thyroid Problems	
AIDS/HIV		Other:			

Place an "X" for all that apply to what you are being seen for today only:					
X-Ray		Ct Scan		MRI	
Ultrasound		Bone Scan		Blood Test	
EMG		NCV		Other:	

Please list any other information you feel we should know

"Movement for Life"

Brunswick Physical Therapy, PLLC.

Medical History (PART II)

Patient Name: _____ Date: _____

MD Follow Update: _____

- **Briefly describe your symptoms :**
  _____
  _____
  _____
- **When did your symptoms start? _____**
- **How did your symptoms start?**
  _____
  _____
  _____
- **What makes your symptoms better? (circle all that apply): Sitting Standing Bending Lying Down Walking Other: _____**
- **What makes your symptoms worse? (circle all that apply): Sitting Standing Bending Reaching Lifting Bending Lying Down Walking Other: _____**
- **Is your pain …. Constant / Intermittent / Not applicable**

How would you rate your pain?

At Best 0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

At worst 0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Today 0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain