Orthopedic Physical Therapy Specialists, Inc.

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Patient Medical Information Sheet

Please complete all sections in full

Name: _____ Date: _____

Diagnosis: _____ Date of Birth: ____/____/____

Physician who ordered Physical Therapy: _____

Date of next Physician's appt: ____/____/____

Past Medical/Surgical History:
Check Yes or No:

☐ Yes ☐ No Arthritis
☐ Yes ☐ No Asthma
☐ Yes ☐ No Angina/Chest Pain
☐ Yes ☐ No Allergies
☐ Yes ☐ No Bowel/Bladder Problems
☐ Yes ☐ No Bronchitis
☐ Yes ☐ No Cancer
☐ Yes ☐ No Circulatory Problems
☐ Yes ☐ No Currently Anxious
☐ Yes ☐ No Currently Depressed
☐ Yes ☐ No Currently Pregnant
☐ Yes ☐ No Currently Under Stress
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Difficulty Breathing
☐ Yes ☐ No GI/Abdominal Problems
☐ Yes ☐ No Headaches
☐ Yes ☐ No Heart Attack/Heart Disease
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Hernia
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Liver/Kidney Disorder
☐ Yes ☐ No Lung Problems/Emphysema/ COPD
☐ Yes ☐ No Motor Vehicle Accident
If Yes When: ___/___/___
☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Muscular Dystrophy
☐ Yes ☐ No Metal Implants/ Joint Replacements
☐ Yes ☐ No Osteoarthritis
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Parkinson's Disease
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Seizures/Epilepsy
☐ Yes ☐ No Sexually Transmitted Disease
☐ Yes ☐ No Sport/Orthopedic Injuries
☐ Yes ☐ No Stroke
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Work Related Injury
If Yes When: ___/___/___

Other (Please List): _____

Previous Hospitalization(s)/Surgeries(Please describe): _____

_____

_____

Allergies: _____

☐ Latex ☐ Adhesive Tape

Recent Tests(Check all that apply): ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Blood Work
If so, when? _____

What were the results? _____

In the past 3 months have you had or do you experience:

☐ Yes ☐ No A change in your health?
☐ Yes ☐ No Nausea/vomiting?
☐ Yes ☐ No Fever/chills/sweats?
☐ Yes ☐ No Unexplained weight loss?
☐ Yes ☐ No Numbness/tingling?
☐ Yes ☐ No Changes in appetite?
☐ Yes ☐ No Difficulty sleeping?
☐ Yes ☐ No Difficulty swallowing?
☐ Yes ☐ No Changes in bowel/bladder?
☐ Yes ☐ No Shortness in breath?
☐ Yes ☐ No Dizziness?
☐ Yes ☐ No Upper respiratory infection?
☐ Yes ☐ No Urinary tract infection?

Do you or have you in the past smoked tobacco? ☐ Yes ☐ No
If yes, _____ packs x _____ years. Last tobacco use ___/___/___.

Do you drink alcohol beverages? ☐ Yes ☐ No If yes _____ drinks/week.

History of Current Condition:
Briefly describe in your own words when your pain and/or symptoms began and what caused your current condition:

_____

_____

_____

_____

Onset date: ___/___/___.

What makes your symptoms worse? _____
_____

What makes your symptoms better? _____

_____

Behavior of symptoms over 24 hours (morning, throughout day, evening):_____

_____

_____

_____

Do you have problems completing everyday activities, hobbies, sports, recreational activities, or home projects because of your current condition? ☐ Yes ☐ No

If yes, explain: _____

_____

Have you had any previous therapy for this same condition? ☐ Yes ☐ No
If yes, when? ___/___/___.

What are your goals of Physical Therapy? (ie. decrease pain, return to sport/work, increase strength/flexibility, learn appropriate exercise to prevent re-injury,etc.)

_____

_____

Educational Needs:

How do you best learn? ☐ Pictures ☐ Reading ☐ Listening ☐ Demonstration ☐ Other

Do you have a problem with: ☐ Hearing ☐ Speech ☐ Vision ☐ Communication

Current Medication(s): _____

_____

_____

Occupation: _____

Hobbies/Recreational activities: _____

_____

Pain Ratings: If you have pain, rate it on a scale from 0-10, with "0" being absolutely no pain and "10" being the most severe pain you can imagine, (ie. in which you would need to go to the hospital).

Currently _____/10 At worse /10 At best ___/10

I understand that I have an active role in the development of my treatment plan. In order for me to receive the best care, my healthcare providers need an accurate and up to date medical history. As the patient, I understand that I am responsible for providing this information.
Signature of Patient/Legal Guardian _____
Date ___/___/___

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
By signing below, I acknowledge that a copy of the Notice of Privacy Practices of Orthopedic Physical Therapy Specialists, Inc. was provided to me.

_____ _____
Signature of Patient or Personal Representative Date

_____

Print Name Signed Above

Communication Preference

Please communicate via: □Home Phone □Mobile Phone # to use: (_____) _____ - _____
My Preferred Method of Communication is: □ Phone Call □Text message (requires mobile #)
E-Mail Option: □ Including health messages and appt. reminders via e-mail noted below:
_____
Message can be left on/with (check all that apply.)
Spouse/Family member _____ Voice Mail or answering machine_____ Employer _____
I authorize OPTS, Inc. to contact me via direct mail, e-mail, mobile text message (standard txt & data rates may apply), or telephone (including pre-recorded telephone calls) for purposes of appointment reminders, health messages or current in-office specials that may be of interest to me. I understand that I can opt-out of these communications at any time by informing the front desk.
Patient Signature: _____ Date: _____