(802) 497-0923

REHAB ZONE PHYSICAL THERAPY
20 Kimball Avenue Suite 204 South Burlington, VT 05403 Phone (802) 497-0690 Fax

Medical History

Patient Name_____ **Pronouns:**_____ **Date**_____
Allergies_____ **Primary Care Physician**_____
Current Medications_____
_____

Check those conditions that apply to you:

- ☐ **Heart Disease**
- ☐ **Respiratory Disease**
- ☐ **Diabetes** – *Taking insulin? Yes / No*
- ☐ **Seizure Disorder** – *Date of last seizure* _____
- ☐ **CVA** *(Cerebrovascular accident or stroke) Date*_____
- ☐ **High Blood Pressure**
- ☐ **Current pregnancy** *Due Date*_____
- ☐ **Dizziness / Fainting / Nausea** *(please circle)*
- ☐ **Recent Surgeries** *Type/Date*_____
- ☐ **Depression**
- ☐ **Alcohol abuse history**
- ☐ **Drug abuse history**
- ☐ **Smoker** *How much?*_____ *How many years?*____
- ☐ **Cancer** *What Type?*_____
- ☐ **Infectious Disease** *Explain*_____
- ☐ **Other** _____

Please describe your current symptoms:

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50 % of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms.

What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

How are your symptoms changing?

- ☐ Getting better-
- ☐ Not changing
- ☐ Getting worse

During the past 4 weeks

• Please indicate on the line where your pain is in relation to the 2 extremes

No pain ***Worst Pain***

_____

• How much has pain interfered with your normal work activities?

Not at all **A little bit** **Moderately** **Quite a bit** **Extremely**

• How much has pain interfered with your normal daily living activities?

Not at all **A little bit** **Moderately** **Quite a bit** **Extremely**

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Patient Signature_____

Date_____