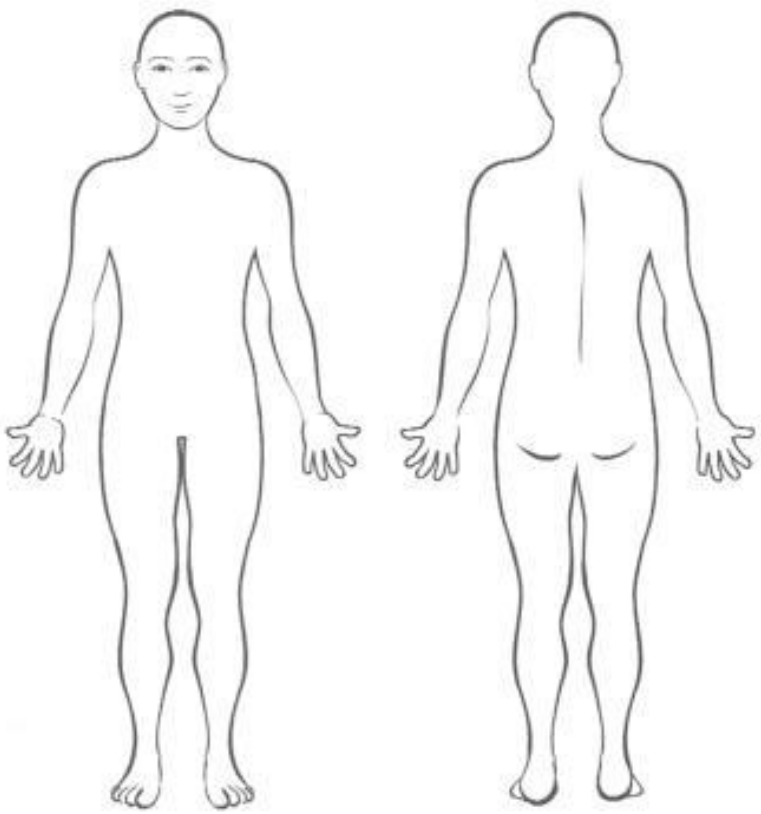
MOSAIC
physical therapy

New Patient Medical History Form

Patient Last Name: _____First Name: _____

Type of Injury / Condition: _____

Onset / Injury Date: _____ Type of Surgery: _____ Surgery Date: _____



✓ Please circle the location of your pain on the body charts to the left

✓ If you have any other symptoms, such as numbness or tingling, circle the location with a dotted line -- -- -- --

✓ On the scale below, circle the number that best describes your level of pain

10	Pain is as bad as it can be
9	
8	
7	Pain is Severe
6	
5	Pain is Moderate
4	
3	Pain is Mild
2	
1	Pain is Slight
0	No Pain

Have you had any imaging performed?

□ X Ray □ CT Scan □ Ultrasound □ MRI □ Doppler

Have you recently noted:

□ Weight Loss or Gain □ Nausea or Vomiting □ Fatigue □ Weakness □ Fever/Chills/Sweats
□ Pregnancy / IUD □ Headache □ Numbness / Tingling □ Change in vision □ Change in hearing
□ Pain at night □ Insomnia □ Cramps when walking

Do you have now or have you ever had any of the following?

□ Surgeries □ Diabetes □ Fractures □ Loss of Consciousness □ Cancer
□ Sprains / Strains □ Heart Problems □ Blood Pressure Problems □ Circulation problems / Clots □ Motor Vehicle Accident
□ Asthma/Breathing Problems □ Lung Disease □ Easy Bruising / Bleeding □ Leg / Ankle Swelling □ Metal/Pins/Plates or Pacemaker in Body?
□Indigestion / Heartburn □ Fainting □Allergies /Skin Sensitivity □ Urinary Problems / Infections

Do you have any injury that may affect current care? _____

Explain and give approximate dates for any of the noted items above:_____

_____

Are you currently taking medications? □ Yes □ No Name and type of medication(s): _____

On a scale of 0 to 10, how much stress do you have in your life? □ 0 - No Stress □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 Severe Stress

What are your current physical fitness activities? _____

Have you had any Physical Therapy Treatments before? □ Yes □ No If yes, where? _____

Is there anything you would like to include or ask? _____