



**ATLANTA FALCONS PHYSICAL THERAPY CENTERS
MEDICAL HISTORY FORM**

Full Name of Patient:

Date of Birth: ___M___D___Y

Reason for Therapy:

Date of Injury/Symptoms: ___M___D___Y

Chief Complaint/Concern:

Date of First Doctor Visit: ___M___D___Y

Please indicate if you have received any of these services for your injury?

X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myelogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	General Practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> No
MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedist	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT-Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologist	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Massage Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	ER Care	<input type="checkbox"/> Yes <input type="checkbox"/> No

Did you have surgery for this injury? If yes, please describe and provide the procedure date(s). If no, please write "none."

Have you ever experienced the following? (If yes is checked for any item, please describe on the reverse side of this form.)

General/Constitutional		Cardiovascular		Musculoskeletal	
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Pain/Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Weight Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night Sweats/Fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain or Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery/Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory		Neurological		Gastrointestinal	
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures/Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rectal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine		Hematological/Lymphatic		Ophthalmological	
Excessive Thirst/Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glasses/Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Slow to Heal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred/Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hormone Problem(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enlarged Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Disease/Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear-Nose-Throat		Other		Other	
Hearing Loss or Ringing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast Pain/Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Voice Change	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies		Confusion/Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food and Medical	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check here if you have any additional injury specific or medical history information to share on the reverse side of this form. Include details surrounding any pain you feel, prescription and non-prescription medicine you are currently taking, allergies and associated reactions, and other information to help your therapist customize the right treatment plan for you.

My signature below confirms that the information provided on this document is accurate to the best of my knowledge.

Patient Signature:

Printed Name:

Date:

Parent/Guardian's Signature:

Parent/Guardian's Name:

Date:

PATIENT COMMENTS:

THERAPIST COMMENTS: