## Confidential Medical History/Evaluation

Name: ______________________ Date: ____/____/____ Referring MD: ______________________________

Address: ______________________________ Date of Birth: ____/____/____ Phone: __________ SS#: __________

Insurance Company: ____________________________ Subscriber ID: __________________ Group #: __________

Insured Employer/Address: ______________________________________________ Phone: ______________

Occupation: ______________________ Is this injury? ☐ Work Related ☐ Auto Accident

Chief Complaint: ______________________________________________________ Date of Injury: __________

Height: __________ Weight: __________

List any/all medications you are currently taking: ____________________________________________

Are you allergic to any medications? ____________________________________________

List any surgeries: ____________________________________________

Have you had any Diagnostic or Rehabilitative Services for this Injury? ☐ MRI ☐ Xrays Other: ______________

| Do you have any of the following? | YES | NO |
|---|---|---|
| Asthma, Bronchitis or Emphysema | ____ | ____ |
| Shortness of Breath/Chest Pain | ____ | ____ |
| Coronary Heart Disease | ____ | ____ |
| Do you have a Pacemaker | ____ | ____ |
| High Blood Pressure | ____ | ____ |
| Heart Attack/Surgery | ____ | ____ |
| Stroke/TIA | ____ | ____ |
| Blood Clot/Emboli | ____ | ____ |
| Epilepsy/Seizures | ____ | ____ |
| Thyroid Trouble/Goiter | ____ | ____ |
| Anemia | ____ | ____ |
| Infectious Disease | ____ | ____ |
| Diabetes | ____ | ____ |
| Cancer or Chemo/Radiation | ____ | ____ |
| Arthritis/Swollen Joints | ____ | ____ |
| Osteoporosis | ____ | ____ |
| Varicose Veins | ____ | ____ |
| Gout | ____ | ____ |
| Sleeping Difficulties | ____ | ____ |
| Emotional/Psychological Problems | ____ | ____ |
| Bowel or Bladder Problems | ____ | ____ |
| Severe/Frequent Headaches | ____ | ____ |
| Vision/Hearing Difficulties | ____ | ____ |
| Dizziness or Faintness | ____ | ____ |
| Are you pregnant? | ____ | ____ |

Smoking Daily ________ Weekly ________

Alcohol Consumption Daily ________ Weekly ________

| Pain when performing the following activities? | Mild | Moderate | Severe | Unable |
|---|---|---|---|---|
| Bending | ____ | ____ | ____ | ____ |
| Care for Infirm Family | ____ | ____ | ____ | ____ |
| Carrying Groceries | ____ | ____ | ____ | ____ |
| Change Pos (Sit to Stand) | ____ | ____ | ____ | ____ |
| Climb Stairs | ____ | ____ | ____ | ____ |
| Driving | ____ | ____ | ____ | ____ |
| Extended Computer Use | ____ | ____ | ____ | ____ |
| Feeding (Self) | ____ | ____ | ____ | ____ |
| Household Chores | ____ | ____ | ____ | ____ |
| Kneeling | ____ | ____ | ____ | ____ |
| Lift Children | ____ | ____ | ____ | ____ |
| Lifting | ____ | ____ | ____ | ____ |
| Pet Care | ____ | ____ | ____ | ____ |
| Reading (Concentration) | ____ | ____ | ____ | ____ |
| Self Care-Bathing | ____ | ____ | ____ | ____ |
| Self Care-Dressing | ____ | ____ | ____ | ____ |
| Self Care-Shaving | ____ | ____ | ____ | ____ |
| Sexual Activities | ____ | ____ | ____ | ____ |
| Sleep | ____ | ____ | ____ | ____ |
| Sitting (Prolonged) | ____ | ____ | ____ | ____ |
| Standing (Prolonged) | ____ | ____ | ____ | ____ |
| Walking | ____ | ____ | ____ | ____ |
| Yard Work | ____ | ____ | ____ | ____ |

Sports ______________________________________________

Recreational Activities ______________________________________________

Exercise Daily __________ Weekly __________

Other Medical Conditions ____________________________________________

Are you aware of your Diagnosis? YES ___ NO ___ Are you aware of your Prognosis? YES ___ NO ___

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to PTS regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: ______________________________ Date: ______________