DESERT EDGE
PHYSICAL THERAPY
Move better. Live better.

Patient Medical Information

Patient Name:_____ Age: _____ Today's Date: _____

Current Injury, Surgery, or Pain

Date of Injury: _____ Date of Surgery: _____ Date Pain Started: _____

Referring Physician: _____ Last MD Visit: _____ Next MD Visit: _____

Is your injury related to any of the following?

☐ Work ☐ Car accident ☐ Surgery ☐ Lifting/Carrying ☐ Fall

☐ Slow onset ☐ Athletics ☐ Chronic/Reoccurring

Occupation: _____ Work Status: ☐ FT ☐ PT ☐ Unemployed

Diagnostics performed for this condition? ☐ X-ray ☐ MRI ☐ CT Scan ☐ EEG ☐ EMG ☐ Injections

If yes, date: _____

Have you received treatment for your condition before today? If yes, from whom: _____

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other: _____

Have you recently experienced any of the following:

☐ Dizziness/Lightheaded ☐ Difficulty swallowing ☐ Muscle weakness
☐ Fainting ☐ Changes in bowl or bladder ☐ Numbness/Tingling
☐ Unexplained weight loss ☐ Incontinence ☐ Are you pregnant, # wks_____

Medical History

Have you ever been diagnosed with any of the following?

☐ High/Low blood pressure
☐ Heart problems
☐ Stroke/CVA
☐ Pacemaker
☐ Blood clots/Circulation issue
☐ Diabetes: Type 1/Type 2
☐ Osteoporosis
☐ Arthritis: OA/RA
☐ Cancer
☐ Bladder/Urinary/Kidney Disease
☐ Lung Problems COPD/Emphysema
☐ Tobacco use: #_____/day
☐ Asthma
☐ Seizures
☐ Neurological disease: MS/Parkinson's
☐ Depression/Anxiety/Panic
☐ Back pain: Degenerative/Stenosis/Herniation
☐ Back injury
☐ Neck injury
☐ Chronic headaches
☐ Other injury
☐ Fracture _____
☐ TB/HIV/Hepatitis A, B, C
☐ Visual/Hearing Impaired
☐ Other condition: _____

Surgical History

☐ Joint Replacement(s) *please explain:*_____ *date:* _____
☐ Orthopedic Surgery *please explain:*_____ *date:* _____
☐ Heart Surgery *please explain:*_____ *date:* _____
☐ Fracture Repair *please explain:*_____ *date:* _____
☐ Spinal Surgery *please explain:*_____ *date:* _____
☐ Other Surgeries *please explain:*_____ *date:* _____

Current Medications

Please list your current medications:

☐ See attached list

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that it is important for my therapist to understand my medical history in order to create a comprehensive treatment plan. I certify to the best of my ability, the above information is complete and accurate.

Patient/Guardian Signature _____ Date _____

Patient Name _____

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