McLaren
CARO REGION

PATIENT MEDICAL HISTORY FORM
PHYSICAL THERAPY

NAME: _____ DOB: _____

DATE OF ONSET OF PROBLEM: _____ ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE? ☐ YES ☐ NO

DESCRIPTION OF CURRENT PROBLEM: _____

_____

_____

HOW PROBLEM AROSE: _____

_____

_____

LIMITATION DUE TO CURRENT CONDITION: _____

_____

	DESCRIBE
☐ Heart Problems	_____
☐ Cardiac Pacemaker	_____
☐ High Blood Pressure	_____
☐ Diabetic	_____
☐ History of Cancer	_____
☐ Seizures	_____
☐ Metal Implants	_____
☐ Arthritis	_____
☐ CVA (Stroke)	_____
☐ Fracture	_____
☐ Surgical History	_____
☐ Other	_____

PRESENT MEDICATIONS: _____

_____

DRUG ALLERGIES: _____

_____

DIAGNOSTIC TEST: ☐ EMG ☐ MRI ☐ X-RAY ☐ CT SCAN ☐ OTHER

RESULTS OF TEST: _____

OCCUPATION: _____ WORKERS COMP ☐

EMPLOYER: _____ SSD ☐

WORK PHONE NUMBER: _____ RETIRED ☐

REFERRING PHYSICIAN: _____

FAMILY PHYSICIAN: _____

CONTACT PERSON IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ HOME # _____ WORK # _____