

McGovern Physical Therapy Associates

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MEDICAL AND INJURY HISTORY FORM

Patient Name: _____ **Date:** _____

SOCIAL HISTORY:

Are you pregnant? yes no Is there a possibility that you may be pregnant? yes no

Were you employed at time of injury? yes no Occupation at time of Injury: _____

Has your ability to perform daily tasks, work functions, and /or exercise changed since your injury? yes no

Please Describe: _____

MEDICAL HISTORY: Do you now or have you ever had the following: Please put an **X** next to all that applies

<input type="checkbox"/> Allergies to Latex	<input type="checkbox"/> Heart trouble/Pacemaker	<input type="checkbox"/> Stomach/ulcer
<input type="checkbox"/> Arthritis (Bone,Rheumatic)	<input type="checkbox"/> Hepatitis A B C	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Asthma/ Emphysema	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney/Bladder	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Gout	<input type="checkbox"/> Alcohol/Drug Abuse	Other: _____

PRIOR INJURY HISTORY

Have you had **prior injuries** to your body? Yes or No If yes, See below

List all **PRIOR INJURIES** with **DATES** include any **work related, sports related, motor vehicle related injuries or accidents:** _____

Have you ever had Surgery? Yes or No If yes, please describe and give surgery dates:

What current medications are you taking? Please list and indicate the reason for each drug:

CURRENT INJURY DESCRIPTION

Please **describe in detail** how you became injured: _____

Have you seen a **Doctor** or gone to the **Hospital** for this injury? Yes or No

What is the name of the **Doctor** or

Hospital? _____

Have you had prior **Physical Therapy** or **Chiropractic** care for this injury? Yes or No If yes, when and what was the name of the Facility? _____

_____ Did you get better, worse, or the same? Please describe: _____

Patient Signature: _____ **Date:** _____
