

McGovern Physical Therapy Associates

350 Main Street, 1st Floor Malden, MA 02148 Ph: (781) 321-2727 Fax: (781) 321-4995

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

() Allergies to Latex	() Heart trouble/Pacemaker	() Stomach/ulcer
() Arthritis (Bone,Rheumatic)	() Hepatitis A B C	() Thyroid problems
() Asthma/ Emphysema	() AIDS/HIV	() Tuberculosis
() Cancer/Tumors	() High Blood pressure	() Osteoporosis
() Diabetes	() Kidney/Bladder	() Mental Illness
() Frequent Headaches	() Artificial Joints	() Seizures/Epilepsy
() Gout	() 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:** _____

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

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

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CURRENT INJURY DESCRIPTION

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

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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:** _____
