evolution
PHYSICAL THERAPY + YOGA

MEDICAL HISTORY FORM

Please take a moment to complete this form. Thank You.

Name: _____

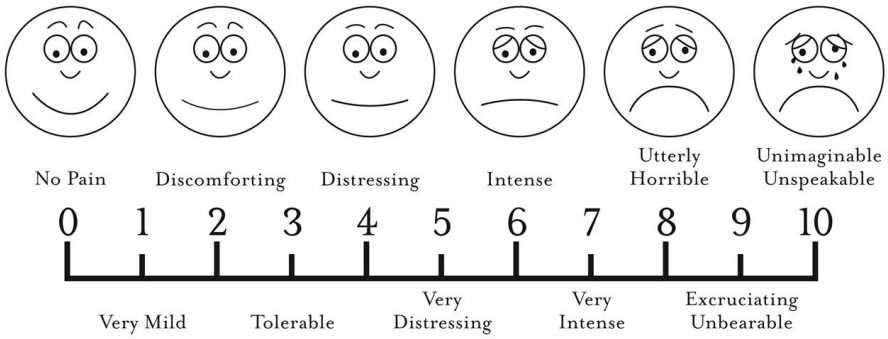
Age:_____ Height: _____ Weight: _____

What are you are being seen for today? _____

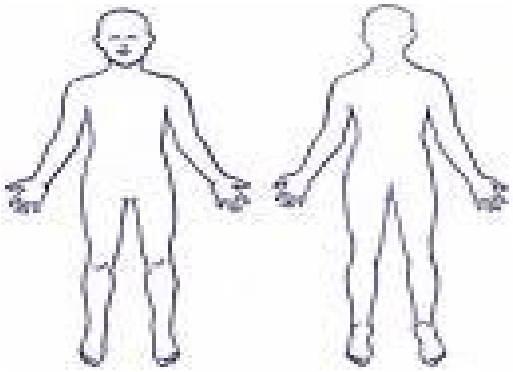
How did the symptoms start? _____

Date of Onset: _____ Area of Symptoms:_____

Please use circles below to rate your current and worst pain levels:



Please mark on the picture below where you are experiencing symptoms:



//// Stabbing pain
XXX Burning
ooo Pins and needles
=== Numbness
+++ Ache

What activities/movements does your current condition prevent you from participating in fully?

Activity	**% Ability to Perform** (0% unable to perform – 100% full performance)
_____	_____
_____	_____
_____	_____

Have you had any diagnostic tests (x-ray, MRI, CT, etc)? Is yes, please list known results.

_____

_____

Have you fallen in the past year? YES ☐ NO ☐

Are you currently taking any medications or supplements? YES ☐ NO ☐

If yes, please list:_____

_____

Please check off any treatment that you have received for this injury:

☐ visit to Primary Care Physician ☐ visit to Specialist:_____

☐ Physical Therapy ☐ Chiropractic

☐ Acupuncture ☐ Massage

☐ Injections ☐ Surgery

Do you currently have or have you ever had any of the following?

Anxiety	YES ☐	NO ☐	Are you pregnant?	YES ☐	NO ☐
Depression	YES ☐	NO ☐	Incontinence	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Constipation	YES ☐	NO ☐
Night Pain	YES ☐	NO ☐	Abdominal Surgery	YES ☐	NO ☐
Recent Weight Loss	YES ☐	NO ☐	Osteoporosis	YES ☐	NO ☐
High Cholesterol	YES ☐	NO ☐	Epilepsy or Seizures	YES ☐	NO ☐
Heart Disease	YES ☐	NO ☐	Diabetes	YES ☐	NO ☐
High Blood Pressure	YES ☐	NO ☐	Thyroid Problems	YES ☐	NO ☐
Pacemaker	YES ☐	NO ☐	Respiratory Problems	YES ☐	NO ☐

Other medical issues?_____

Please list any surgeries you have had and dates, even those that may not seem relevant:

_____

_____

Have you been pregnant? _____ If so, how many births and type of birth (c-section, vaginal, complications?) _____

List current fitness or recreational activities that you do regularly_____

_____

Occupation_____

Do you smoke or use other tobacco products?	YES	NO
Do you consider yourself to have good dietary habits?	YES	NO
Do you have any known allergies such as food, environmental, drug?	YES	NO

_____

List foods in your diet that you eat during a typical day _____

_____

_____ _____

Patient Signature Date