



# EMPIRE PHYSICAL THERAPY & Athletic Rehabilitation, PC

## Confidential Medical History

Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ S.S #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Gender: Male / Female

Marital Status: M/S Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Body Part: \_\_\_\_\_

Insurance: I.D #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ **Work related injury? YES / NO** **Auto accident? YES / NO**

Any Diagnostic or Rehabilitative services for this injury? MRI / X-ray's / Other: \_\_\_\_\_

List any additional surgeries: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

Any allergies? YES / NO If so, please list: \_\_\_\_\_

### Do you have any of the following:

	Yes	No
Asthma, Bronchitis, Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath / Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack / Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot / Emboli	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Trouble / Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Chemo / Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Severe / Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Vision / Hearing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Faintness	<input type="checkbox"/>	<input type="checkbox"/>

### Pain when performing the following:

	Mild	Moderate	Severe
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Computer Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting (prolonged)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing (prolonged)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	Daily _____	Weekly _____	
Are you pregnant?	_____		