ProActive
REHABILITATION & WELLNESS

2103 Reedale Ave
Augusta, GA 30906
(706) 814-6887

Name:_____
Date of Birth:_____

Medical History Information

1. Please describe your reason for coming to ProActive (e.g. "back pain" or "hip replacement.")- _____ When did it occur or begin? _____

2. Do you now have any of the following problems? Check Yes (Y) if you currently have the problem. Check No (N) if you do not currently have the problem.

Problem	Y	N	Explain	Problem	Y	N	Explain
Surgical implant				Kidney disease/stones			
Pacemaker				Hepatitis			
Heart problem				Liver disease			
Chest pain				Ulcers			
Vascular disease				Osteoporosis			
High blood pressure				Previous fractures			
High cholesterol				Arthritis/gout			
Shortness of breath				Rheumatoid arthritis			
Asthma				Lupus			
Sleep Apnea				Fibromyalgia			
Other breathing problem				Urinary tract infection			
Diabetes				Stroke/TIA			
Hypoglycemia				Headaches			
Cancer				Seizures			
Thyroid Problems				Multiple Sclerosis			
Anemia				Guillain Barre			
Thinning of blood				Immune System Compromise			
Blood clots				Infection			
Anxiety/ Depression				Substance Abuse			

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3. Please list any surgeries that you have had and their dates:

_____

_____

_____

_____

4. Please list any adverse reactions or allergies to medications or foods:

_____

_____

_____

5. Please tell us if you or an immediate family member have been diagnosed or treated for these conditions? Check Self (S) if you, or Family (F) if your parent, sibling or child has ever had the problem.

Problem	S	F	Explain	Problem	S	F	Explain
Pacemaker				Hepatitis			
Heart problem				Liver disease			
Chest pain				Ulcers			
Vascular disease				Osteoporosis			
High blood pressure				Previous fractures			
High cholesterol				Arthritis/gout			
Shortness of breath				Rheumatoid arthritis			
Asthma				Lupus			
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Thyroid Problems				Multiple Sclerosis			
Anemia				Guillain Barre			
Thinning of blood				Immune System Compromise			
Blood clots				Infection			
Anxiety/ Depression				Substance Abuse			

6. Please answer these questions about your general health.	Yes	No	Explain
Are you allergic to anything that touches your skin (e.g. Latex or tape?)			
Do you have any open wounds/sores or rashes?			
Is there any chance that you might be pregnant?			
Have you had any illness in the last 3 weeks (e.g. influenza, bladder infection)			
Have you noticed any lumps or thickening of your skin or muscle?			
Have you noticed any moles or warts that have changed in appearance?			
Have you recently had fever, chills or night sweats?			
Is your weight stable (not gaining or losing more than a few pounds?)			
Are you following a special diet prescribed by a doctor?			
Have you had any recent changes in your bowel or bladder habits (difficulty starting urination, urinary frequency, loss of bowel or bladder control?)			
Have you had any recent headache, nausea/vomiting, ringing in the ears, or vision changes?			
Have you had any recent lightheadedness, dizziness, feeling like you might faint, or loss of consciousness?			
Have you had any recent weakness or sense of fatigue?			
Have you had an organ transplant?			
Do you use tobacco? If yes, how much?			
Do you drink alcohol? If yes, how much?			
Have you fallen in the last 6 months? If yes, how many times?			
Do you have difficulty getting up from a chair without using your arms?			
Do you have hypersensitivity to heat or cold?			
Have you had any physical therapy, anywhere, for any condition in the past 12 months? If yes, when and where?			
Has any doctor ever told you that you should limit your activities?			

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7. Please list any medications, prescription or over-the-counter, that you are presently taking.

☐ List Attached ☐ Second page attached ☐ None

Medication	Dose	Frequency	Reason

8. Please tell us any medical information that we didn't ask about, that you think is important for your therapist to know._____
_____
_____
_____

9. On a scale of 1 (lowest) to 10 (worst), please rate your *current pain level*: _____
10. On a scale of 1 (not limited) to 10 (very limited), please rate your *motion*: _____
11. On a scale of 1 (not limited) to 10 (very limited), please rate your *function*: _____

I certify that the above information accurately describes my medical history and that I will notify my PT immediately of any changes in my medical history.

Signature_____ Date:_____

I have reviewed this information with the client and made comments (authenticated by my initials.)

Therapist Signature/Credentials _____ Date/Time:_____