Green Mountain REHAB & Sports Medicine

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Please tell us about your medical history. Do you know, or have you ever had a problem with any of the following? (if YES, please explain in the space provided):

NO **YES**

□ □ Hearing/Vision/Speech _____
□ □ Arthritis _____
□ □ Bone/Muscle/Joint Injury or Surgery_____
□ □ Heart/Lungs/Blood Pressure_____
□ □ Cancer _____
□ □ Diabetes _____
□ □ Thinking/Memory _____
□ □ Other medical problems not listed? _____
□ □ Women: Are you pregnant? _____

Height: _____ Weight:_____

Do you have pain today? Yes No

If yes, please rate your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate pain Worst pain

Please list the following:

Medications: _____

Allergies: _____

Occupation/Job Duties (if retired or not working, please state): _____

Other activities/hobbies: _____

What injury/problem brings you to PT today? _____

_____ _____

Patient's Signature Date