



MEDICAL INFORMATION SHEET

OPT #6

oxfordphysicaltherapy.com

Name Age Date

Employer Occupation

Emergency Contact Relationship Phone

Social and Vocation Services are available to you at no charge. If you wish to access these services, check here: []

What, if any, treatments have you had for this current problem? _____

List medications by name you are presently taking: _____

Have you ever done aquatic therapy before? [] Yes [] No Where? _____

List any Allergies including Drug and Medication Allergies: _____

Have you had X-Rays or other tests for your current problem? [] Yes [] No

If yes, list test, date, and results: _____

Have you had an MRI? [] Yes [] No Findings: _____

Have you ever been diagnosed or treated for (circle all that apply): Heart Disease HIV(+) Ulcers Cancer Stroke High or Low B/P Arthritis Epilepsy Osteoporosis Diabetes Asthma Hepatitis Tuberculosis

In order to receive maximum therapeutic benefits, please list any other disease and significant medical history that was not mentioned above (such as previous fractures, surgeries, auto accidents, or trauma): _____

Do you have exercise induced asthma? [] Yes [] No Are you pregnant? (Women only) [] Yes [] No

Do you have any numbness or tingling? [] Yes [] No

What in particular makes your pain worse? _____

What if anything eases your pain? _____

Once you start moving about, does the pain ease? [] Yes [] No Once you start moving about, does the pain worsen? [] Yes [] No

What hobbies or sports activities are you involved in? _____

Are you [] Right or [] Left handed? Do You Smoke? [] Yes [] No How many packs per day? _____

What activities are involved in your job? _____

Are you currently working? [] Yes [] No Restrictions: _____

Is there a return date set? [] Yes [] No Date: _____ Have you ever had anything similar before? [] Yes [] No

At the present time do you consider you are getting: [] Better [] Worse [] Stable

Now is there anything else that you think I should know? _____

What are your goals in attending Physical Therapy? _____

Rate your pain: (Check 1) [] 0 = no pain [] 2 = mild [] 4 = discomforting [] 6 = distressing [] 8 = horrible [] 10 = excruciating

Please shade in areas on the diagram below using the following key:

Numbness ☼☼☼

Sharp ✂✂✂

Ache ≡≡≡

Throb ///

Burn ■■■

