970 Millpond Rd. Suite A, Valparaiso, IN 46385 Phone: 219-707-5470

TLC PHYSICAL THERAPY, LLC

Medical History Form

Name: _____ Phone: Cell: _____

Address: _____ Home/Work: _____

City: _____ State: _____ Zip: _____

Marital Status: S M W D Date of birth: _____ Sex: F M Age: _____

Email address: _____

Have you had any other physical therapy this calendar year? Yes No

If yes, are you currently still receiving treatment? Yes No

Have you had any home health services in the last 60 days? Yes No

Employment/Work:

Retired Homemaker Student Unemployed Work full time Work Part-time Medical Leave

Employer: _____ Occupation: _____

Medical/surgical history: please check if you have ever had:

☐ High blood pressure	☐ Heart Problems	☐ Arthritis
☐ Diabetes	☐ Multiple sclerosis	☐ Cancer: _____
☐ Stroke	☐ Hepatitis	☐ Alcoholism
☐ Osteoporosis	☐ Kidney disease	☐ Drug Dependency
☐ Asthma	☐ Anemia	☐ Depression
☐ Emphysema	☐ AIDS	☐ Thyroid problems

☐ Other: _____

Please list any surgeries you have had, including the approximate date:

Date	Surgery
_____	_____
_____	_____
_____	_____

What is your chief complaint: _____

When did the problem begin: Month: _____ Year: _____

What tests or treatment have you had for this problem: _____

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If you have pain, where is it located: _____

Is it: □ Constant □ Intermittent □ Sharp □ Dull □ With intercourse □ Sitting □ Standing

On a scale of 0-10, what is your current level of pain: _____ Worst pain: _____ Best: _____

What is your goal to achieve from physical therapy: _____

When do you return to see your physician: _____

Within the past year have you had any of the following symptoms:

□ Bladder Problems □ Bowel Problems □ Nausea//vomiting □ Weight loss or gain

□ Headaches □ Difficulty sleeping □ Pain at night □ Fever/chills/sweats

If you are here for bladder/bowel problems, please answer the following questions:

Women Only:

How many pregnancies have you had? _____ How many births? _____

How many vaginal births: _____ How many cesareans: _____

Have you reached menopause: _____ Age at onset of menopause: _____

Men Only:

Your last PSA # was: _____ Gleason score: _____

Has your prostate been removed: Yes No Date of surgery: _____

Any radiation: Yes No

Do you leak urine/stool when you:

□ Laugh □ Cough □ Sneeze □ Change position □ Exercise □ Have sex

□ Walk to the toilet □ Pull pants down □ Walk in the house □ Unaware of it

How many pads do you use a day: _____ Type of pad: _____