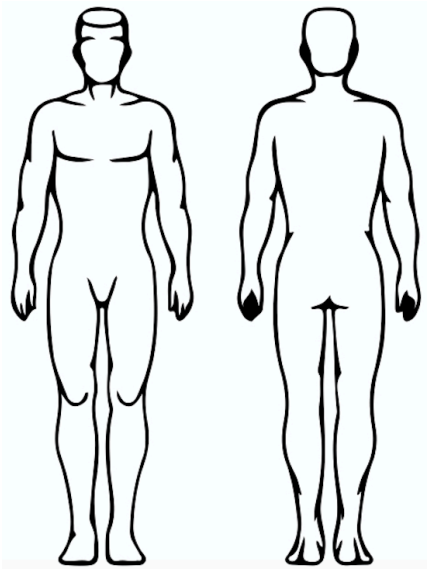
SISU THERAPIES

PATIENT MEDICAL HISTORY FORM

(please fill out thoroughly)

Name	Sex	Today's Date	Birthdate	Emergency Contact and Phone #
Address	Email		Cell Phone	Patient Employer: Duty: ☐ PT ☐ FT
Doctor Name Doctor Location	**Have you had therapy anywhere this year?** ☐ yes ☐ no If yes: # of visits _____ **Are you getting in home care?** ☐ yes ☐ no			**Is this condition:** 1. Fall related? ☐ yes ☐ no 2. Automobile related? ☐ yes ☐ no 3. Work related? ☐ yes ☐ no
How do you learn best? ☐ hearing ☐ seeing ☐ doing			**Do you have difficulty:** ☐ hearing ☐ seeing ☐ speaking ☐ reading	
How did you hear about us? (circle) ☐ doctor referred (write name): ☐ tv commercials ☐ drive by ☐ been here before ☐ friend ☐ other:				

WHAT IS YOUR CURRENT CONDITION/ISSUE?_____



Is this the first episode?

☐ yes ☐ no If no, when was the first episode?

Symptoms start date:

Symptoms are:

☐ constant ☐ intermittent ☐ chronic ☐ new

☐ getting better ☐ getting worse ☐ same

Where is your pain?

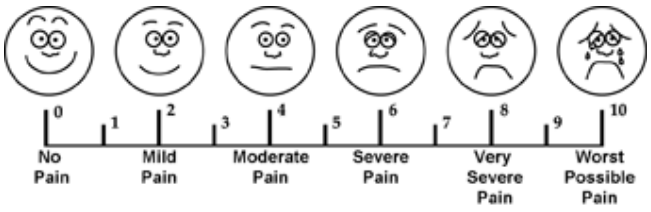
← Mark on the person where your pain is and note type of pain.

Pain Intensity:

____/10 current

____/10 at best

____/10 at worst



Pain gets better:

☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

Pain gets worse:

☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

What is limited because of current complaint:

☐ sleep ☐ self-care ☐ housework ☐ reaching ☐ lifting ☐ sitting ☐ standing ☐ bending ☐ community access ☐ work

Sleep position:

☐ back ☐ belly ☐ right side ☐ left side ☐ recliner ☐ restless ☐ other:

Any other notes:

-MEDICAL HISTORY-

Other Recent Symptoms

Have you recently noted any of the following? (check all that apply)

☐ Extreme fatigue	☐ Anxious or down	☐ Shortness of breath
☐ Constipation/diarrhea	☐ Dizziness/light headed	☐ Numbness/tingling
☐ Visual changes	☐ Muscle weakness	☐ Heartburn/indigestion
☐ Incontinence	☐ Bowel/bladder changes	☐ Unexplained cough
☐ Fainting	☐ Unexplained weight gain/loss	☐ Swelling
☐ Nausea/vomiting	☐ Rapid heart rate/palpitations	☐ Brain fogginess
☐ Fever/sweats/chills	☐ Recent onset of headaches	☐ Other:

Past Diagnosis(s)

Have you ever been diagnosed with any of the following? (check all that apply)

☐ Cancer	☐ Asthma	☐ Bladder/urinary/kidney
☐ Diabetes I or II	☐ Thyroid condition	☐ GI disease
☐ Cardiovascular	☐ Bone/joint infection	☐ Depression/anxiety
☐ Respiratory	☐ Seizures	☐ Neurological disease
☐ Vascular(Strokes, etc)	☐ Chronic headaches	☐ Visual/hearing impairments
☐ Infectious disease(s)	☐ Arthritis	☐ High/low blood pressure
☐ TB/HIV/Hepatitis	☐ Chest pain	☐ Other:

Please list ALL

Surgeries/injections.	
Imaging. Check and date:	☐ Xray ☐ CT Scan ☐ MRI ☐ other:
Other practitioners you have seen for treatment:	
Falls or traumas:	
Do you have allergies to:	☐ latex ☐ cold ☐ heat ☐ medications Any other allergies?

List current medications/vitamins/supplements: You can bring in a document containing this if you wish.

Name	*Purpose*

Health Considerations:

Smoking: ☐ currently ☐ history

Alcohol: ☐ currently ☐ history __drinks/week

Pregnancy: ☐ currently __# of weeks along __# of total pregnancies

To the best of my ability, I have included all pertinent medical information. I also give consent to receive therapy by qualified staff and/or participate in fitness or physical activity opportunities.

Patient/Guardian Signature: _____ Date: _____

-Sisu Therapies thanks you for your completeness; we promise it will help give you great care!