prana
FUNCTIONAL MANUAL THERAPY
A Holistic Physical Therapy Center

MEDICAL HISTORY FORM

Patient Name: _____Date of Birth: _____ Date: _____

Email: _____ Address: _____

Emergency Contact (name, relationship to patient, & phone): _____

Height: _____ Weight: _____ Right/Left Hand Dominant: _____

What area are we treating you for?_____

On a scale from 0-10 (0= no pain, 10= unbearable pain), please rate your current pain level: _____

What makes the pain/problem better? _____

What makes the pain/problem worse? _____

Date of onset/injury/surgery:_____ If injury, was it work related?_____ or Auto related?_____

In the last year, have you had Physical Therapy and/or Chiropractic services anywhere else? [ ]Yes [ ]No

Date of next Physician's appointment?_____ Dr.'s Name_____

Which of the following tests have you had for this problem? (Please check) [ ] X-rays [ ] MRI [ ] CT Scan

[ ] Myleogram [ ] Blood Tests [ ] Other_____

Do you have any of the following symptoms? (check all that apply) [ ]Pain [ ]Swelling [ ]Stiffness
[ ]Numbness [ ]Tingling [ ]Paralysis [ ]Weakness [ ]Dizziness [ ] Vertigo [ ] Other

Do you have or have you had any of the following?
(check all that apply)

	Y	N
Arthritis/Joint Disorders	[ ]	[ ]
Asthma/Respiratory Problems	[ ]	[ ]
Bowel/Bladder Disorder	[ ]	[ ]
Cancer	[ ]	[ ]
Chest Pain/Angina	[ ]	[ ]
Diabetes	[ ]	[ ]
Dizziness/Fainting	[ ]	[ ]
Headaches	[ ]	[ ]
Hearing Disorders	[ ]	[ ]
Heart Attack	[ ]	[ ]
Heart Disease	[ ]	[ ]
Heart Palpations	[ ]	[ ]
Hernia	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Hypoglycemia	[ ]	[ ]
Kidney Problems	[ ]	[ ]
Liver/Gallbladder Problems	[ ]	[ ]

	Y	N
Mental Health Disorders	[ ]	[ ]
Nervous System Disorders	[ ]	[ ]
Neurological Problems	[ ]	[ ]
Osteoporosis	[ ]	[ ]
Pacemaker	[ ]	[ ]
Poor balance/falling	[ ]	[ ]
Poor tolerance to heat/cold	[ ]	[ ]
Prosthesis/implants	[ ]	[ ]
Are you Pregnant?	[ ]	[ ]
Recent Fractures	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Seizures	[ ]	[ ]
Skin Abnormalities	[ ]	[ ]
Smoking/Alcohol Use/Abuse	[ ]	[ ]
Stroke/ CVA	[ ]	[ ]
Walking Difficulty	[ ]	[ ]
History of Physical Trauma	[ ]	[ ]
History of Emotional Trauma	[ ]	[ ]

Explain any YES responses and give related dates on the lines below:

_____

_____

_____

Do you have any known allergies? [ ]Yes [ ]No If yes, please list _____

_____

Do you have a sensitivity to latex or to tape/adhesive? [ ]Yes [ ]No

Do you work? [ ]Yes [ ]No If yes, what is your occupation?_____

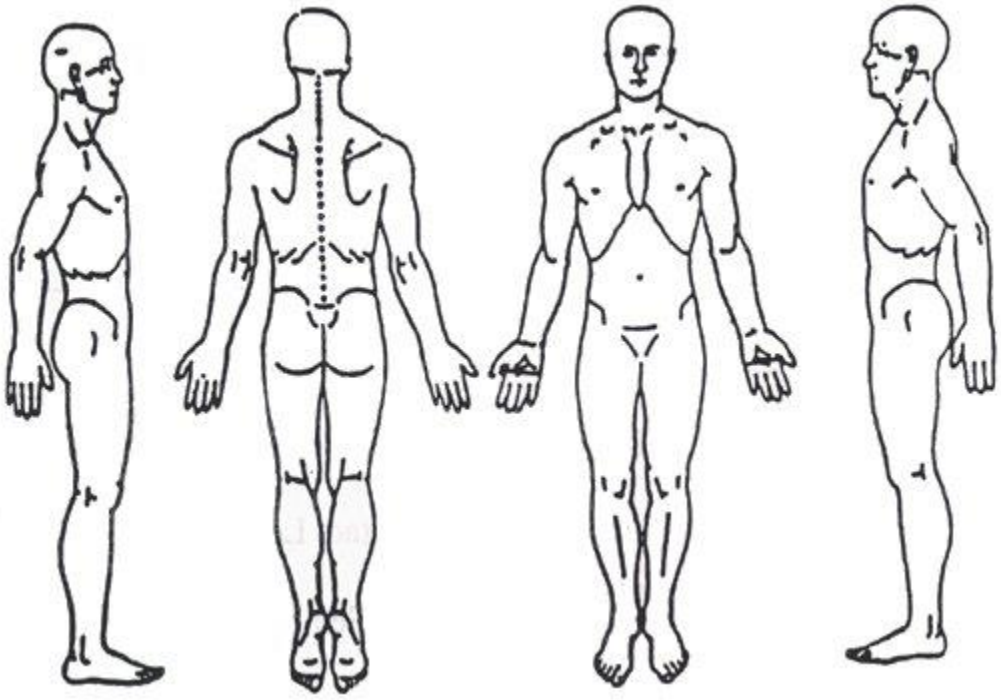
Please list your past surgical history with the dates of surgery included: _____

_____

Please mark the area on your body where you feel the described sensation. Include all affected areas. Use the appropriate symbol.

Numbness: = = = = Pins & needles: 000 000 000 Burning pain: XXX XXX XXX

Stabbing Pain: /// /// /// Aching Pain: (((((((((((((



What medications (over the counter and prescribed) have you taken in the last 24 hours?

_____

_____

_____

How did you hear about Prana Functional Manual Therapy?_____