



OPTIMUM THERAPIES, LLC
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MEDICAL HISTORY FORM

CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

Signature: _____ Date: _____

Do you have any barriers to learning? Yes/No Please list: _____

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Birthdate:	Past Surgical History (list & date)
Age:	
Marital Status:	
Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications:
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Height:	
Weight:	
Do you exercise at least 3 days per week? : <input type="checkbox"/> Yes <input type="checkbox"/> No What type exercises?	

Occupation: _____ Work Duties: _____
 Work-related condition? : Yes No Missed work due to this condition? : Yes No
 Work restrictions: _____

Past Medical History: Please circle each condition that you have been told you have/or had.

- Cancer Diabetes Kidney Disease Stroke
- High Blood Pressure Heart Disease Angina/Chest Pain Fibromyalgia/Myofascial Pain
- Rheumatoid Arthritis Osteoarthritis Osteoporosis Allergies/Asthma
- Lung Disease Have you had a recent illness (explain):

Do you take blood thinners? : Yes No Are you allergic to latex? : Yes No

Do you have metal in your body? : Yes No Where? Other:

Sleep/Emotional Status

How are you able to sleep at night? Fine / Moderate Difficulty / Only with medication

During the past month, have you often been feeling down, depressed, or hopeless? : Yes No

During the past month, have you often had little interest or pleasure in doing things? : Yes No

Body Chart: Please mark the areas where you feel pain on the chart.

Pain Symptoms:

What problem(s) brings you here today?

What date (approximately) did your present pain start?

How (gradually, suddenly, injury)?

My symptoms are currently are:

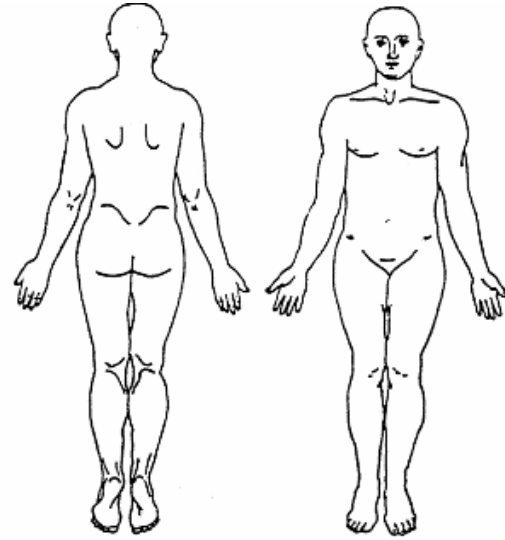
Getting Better / About the same / Getting worse

What treatments have you received for this problem so far?

What make your symptoms better?

What make your symptoms worse?

Have you had an x-ray, MRI or other study for this problem? Yes No



For the Therapist

- +/- cough/sneeze
- +/- Bw/Bldr Change
- +/- Numbness/Tingling

Using the scales below, enter the number which best represent the average level of pain you have experienced over the last 48 hours:

0 1 2 3 4 5 6 7 8 9 10
No pain mild discomfort distressing horrible excruciating

Using the scale below enter the number representing your perceived functional impairment:

0 1 2 3 4 5 6 7 8 9 10
Cannot do Able to do
Any thing everything

What are your personal goals for therapy at this time?
