Ditchfield Physical Therapy

516 Bloomfield Ave Suite #5
Montclair, NJ 07042

Personal Medical History

Name_____ Date:_____

Address_____

_____

Contact: home (____)_____ ____OK to leave message
work (____)_____ ____OK to leave message
mobile (____)_____ ____OK to leave message
Email _____ ____OK to contact me

My preferred method of communication/ appointment confirmations is:
___home phone ___cell phone ___text ____email

Date of Birth _____ Current Age_____

Occupation_____

Employer_____

Primary Care Physician_____

Referred by_____

Spouse/Partner_____

In case of emergency contact _____ at
(___)_____

Signature_____ Date_____/_____/____

Name_____ Date___/____/____

Please describe the condition you are seeking treatment for and give a brief history including onset:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What are your goals for treatment?

_____
_____
_____

What other treatments have you tried for your pain?

_____
_____
_____

List all diagnostic tests you have had (and results) for your current pain/ condition:_____

_____
_____

List all past surgeries and approximate dates:

_____
_____
_____

Name_____ Date___/____/____

List all past injuries and approximate dates:

_____

_____

My pain is worse when __sitting __standing __walking __sleeping
My pain is worse when ___moving ___sedentary

Other things that make my pain
worse:_____

_____

Things that make my pain better:

_____

_____

List ***prescribed*** medications that you currently or have recently taken:
Medication For what condition Side effects?

_____

_____

_____

_____

List ***over the counter*** medications and/or supplements that you currently or have recently taken: **Supplement For what condition? Side effects?**

_____

_____

_____

Please list ***all*** other medical conditions that you have (even if you are not seeking treatment for them here):

_____

_____

_____

*Name*_____ *Date*___/____/____

Are you aware of having or have you been diagnosed as having any of the following conditions or symptoms please check and indicate ***C*** for current or ***P*** for past where appropriate.

Asthma_____ Allergies_____ Chronic Cough_____
Overweight_____ Memory loss_____ Underweight_____
Short leg_____ Phlebitis_____ Scoliosis_____
Sinusitis_____ Migraines_____ Fibromyalgia_____
TMJD_____ Herpes_____ Dental problems____
Chronically cold____ Chronic fatigue_____ Diabetes_____
Dizziness_____ Strength changes_____Tinnitus_____
Bloating_____ Pelvic Pain_____ Painful urination_____
Painful Defecation_____ Chronic diarrhea_____ Incontinence_____
Constipation_____ Hypertension_____ Arthritis_____
Hypotension_____ Osteoporosis_____ Depression_____
Polio_____ Alcoholism_____ Cancer_____
Drug Abuse_____ Seizures_____ Clench/Grind_____
Stroke_____
Sleep disorder_____ Sleep Apnea_____ Auto Immune_____
Fainting_____
Cardiac Arrythmia____ Angina_____ Thyroid disorder_____
Vision changes_____ Abdominal pain_____ Chronic prostatitis____

For Women:
Pregnancies_____ Ages of Children:_____
Menstrual Pain_____ Menopause_____
Pelvic Pain_____

I smoke_____ cigarettes, cigars, pipes per day.
I drink _____ cups of coffee/tea/caffeinated beverage per day.
I drink _____ alcoholic beverages per day.
I drink _____ glasses of fluid per day.
I chew _____sticks of gum per day.
What is your: Height_____ Weight_____
Are you: left handed _____right handed____

Name_____ Date___/____/____

My regular exercise is:

_____

_____

My goals for exercise
are:_____

I sleep _____ hours per night.
I go to sleep at _____ and wake up at _____
My sleep quality is ___great___good ___poor
I have trouble ____falling asleep _____staying asleep _____waking up
When I wake up I feel _____well rested ____still tired
I sleep on my___back ____stomach ___sides
I get up to go to the bathroom _____ times per night
I have ____sleep apnea _____insomnia ____uncomfortable bed
____other sleep condition (specify)

Do you wear glasses? ____No _____Yes
If yes, are they (circle): bifocal progressive reading computer

Are you currently working?___No ___Full time ___Part time
Did you work before your symptoms began? ___Yes ___No
Did your pain make you stop working? ___Yes ___No
What are your main activities at work?
I commute _____minutes/hours to work per day.

I watch _____hours of TV per day I play _____ hours of video game or computer games/web surfing (non- work) on my ___smart phone ___ipad (or similar) ___laptop ___desktop I ___do ___do not use a headset/ ear piece for telephone or cellphone I send (#) ____ texts daily

Ditchfield Physical Therapy requires 24 hours notice for any cancellations.
If notification is not given, client will be charged for the treatment session.

Patient Signature:_____ Date:_____