



Longmont United Hospital

1950 Mountain View Avenue, Longmont, Colorado 80501

Name: _____

Date: _____

MEDICAL HISTORY

Past medical information is very helpful in our decision making with regard to your therapy program. Please answer the following questions as completely as possible.

Medical History: Do you have or did you have (check all that apply):

	YES	NO		YES	NO
Heart Attack Date:			Chronic neck pain		
Pacemaker			Chronic back pain		
Metal implants			Numbness in arms		
Stroke Date:			Numbness in legs		
Head Injury Date:			Weakness in arms		
High blood pressure			Pain in sitting How long can you sit?		
Seizure disorder Date of last seizure			Pain in standing How long can you stand?		
Osteoporosis			Pain with walking How far/long can you walk?		
Asthma			Sleep problems		
Diabetes			Fever or chills (unexplained)		
Cancer			Incontinence Urine Leak Stool		
Pregnant Lactation status:			Allergies Food: Drug:		
Drink alcohol If yes, how much per day?			Environmental:		
Tobacco products? If yes, how much per day?			Special Diet: (in recent 3 months) Unexplained weight loss or gain?		
Surgeries performed List & Date:			Other Medical condition: (that would effect therapy)		

Functional History: Do you have or have you (check all that apply):

	YES	NO		YES	NO
Fallen the last 3 months If yes, explain			History of falls		
Assistive Device (walker, cane, etc.)			Exercise regularly		
Hearing impaired			Vision impaired		
Memory impaired			Language impaired		

Personal History: (check all that apply):

Do you feel safe at home?	Yes	No		
How do you learn best?	Verbally	Reading	Visually	Hands on
Primary language:	English	Spanish	Other:	
Do you have any special needs?	Visual	Auditory	Literacy	Other
Do you have Advance Directives? (Therapist will ask) If yes, system explained. If no, Advance Directive information given	Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	No <input type="checkbox"/> Medical record on file	<input type="checkbox"/> CPR	



MEDICAL HISTORY

Medications: Please list or attach list

Current Problem and history

Current condition that brings you to therapy:

How would you describe your condition?	Constant	Occasional	Frequent	Rare
Worse in the:	Morning	Evening	Night-time	
What makes condition better?	Rest	Ice	Heat	Changing positions
Have you had tests for this condition?	X-ray	CT Scan	MRI	EMG
Where was it done:	LUH	Other	Date:	
Have you had therapy for this condition in the last year?	Yes	No	Where:	

Rate your pain from 0 to 10 (10 being the worst):

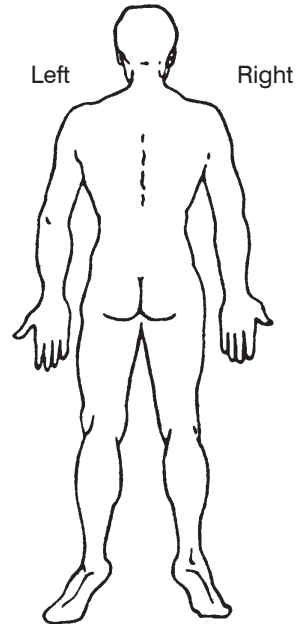
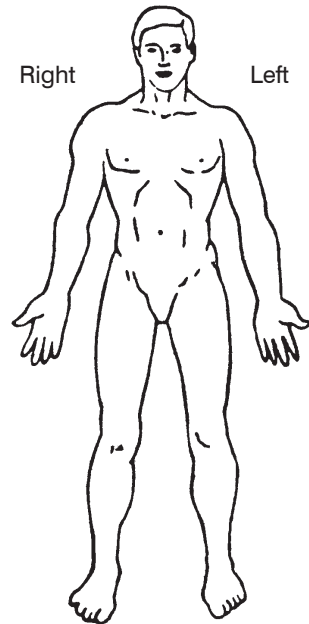
Draw your pain on the diagrams below, use the following key:

///// = stabbing pain

xxxxx = aching pain

ooooo = burning pain

nnnn = numbness



Patient/Guardian Signature

Date

Therapist's Signature