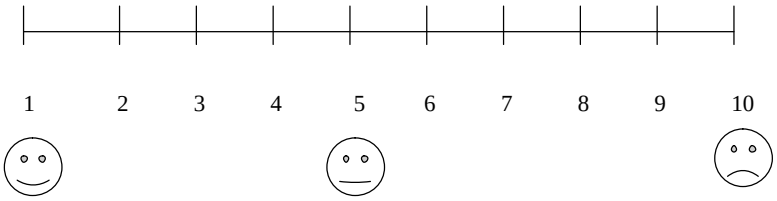
Name: _____
Date of Birth: ____/_____/_____Male / Female

TMI Physical Therapy Medical History

Patient Name: _____ Major complaints/ injury: _____
Surgery: _____ Date of Surgery: ____/____/_____
How did your injury occur? _____
Athletic activities: _____ Are you playing? YES / NO
Are daily activities affected by your condition? YES / NO List those activities: _____

Please list medical conditions/ disease: _____
Please list any previous surgeries: _____
List Current Medications: _____
List Known allergies: _____

Pain assessment: 1 = No Pain at all 10 = Worst Pain



Pain is:	Constant	Minimal	Intermittent	Moderate	Stinging	Aching
Swelling is:	Constant	Minimal	Intermittent	N/A		
Sensations:	Burning	Numbness	Shooting	Tingling	N/A	
Is your General condition:	Better	Worse	Same			
Do you feel better in the:	Morning	Night	N/A			
Do you feel better:	Standing	Sitting	N/A			
You learn best by:	Reading	Performing	Hearing	Watching		

Patient Signature: _____ Date: _____

Print Name: _____ PT Signature: _____