VORTEX
physical therapy & balance

MEDICAL HISTORY

PATIENT INFORMATION	PHYSICIAN INFORMATION
Patient Name:	Primary Physician:
Birthdate:	Referring Physician:

REASON FOR TREATMENT
Diagnosis:
Symptoms:
Onset/Injury Date:
If injured, briefly describe how it occurred:
Have you had similar symptoms before (*circle answer*)? YES NO
Who have you seen for this condition? (*please circle all that apply*) Primary MD ENT Neurologist PT Chiropractor
What medications are you taking? (*Please list all prescription and over the counter medications*):

OCCUPATION (*circle answers below*)				
What is your occupation?				
Employment status:	F/T	P/T	retired	medical leave/disability
Work environment:	Sitting	Standing	Light Labor	Heavy labor
Provide brief job description:				

GENERAL FITNESS/LIFESTYLE (circle answers below)				
Describe your fitness level:	Poor	Fair	Good	Excellent
How often do you exercise (weekly)?	None	1-2 x	3-4 x	5+ x
General stress level:	Low	Moderate	High	Overwhelmed
Have you used tobacco in the past year? YES NO		If yes, how often?		
Do you drink alcohol? YES NO		How many drinks per week?		

Patient Name: _____ Date: _____

PAST MEDICAL HISTORY

Please check to confirm if you have been diagnosed with any of the following. If you are unsure about a particular item, please leave it blank and discuss with your therapist

Auto-Immune Disease
- Systemic Arthritis (RA, Lupus, other) ☐
- Unexplained rashes, sores, swelling ☐
- Fibromyalgia/Chronic Fatigue ☐
- Multiple Sclerosis (MS) ☐
- Severe cold intolerance/Raynaud's ☐

Blood Disorders
- Bleeding disorders ☐
- Clotting disorders/DVT ☐
- Blood thinners ☐
- Peripheral vascular disease ☐

Cancer
- History (if yes, type)_____ ☐

_____

Cardiovascular
- Heart attack ☐
- Chest pain or Angina ☐
- Fainting ☐
- Heart rate restrictions w/ exercise (MD) ☐
- Pacemaker ☐

Endocrine/Metabolic
- Diabetes ☐
- Osteoporosis ☐

Neurologic
- Stroke/TIA ☐
- Parkinson's ☐
- Seizure disorder ☐
- Poor balance/frequent falls ☐
- Recent tremors/clumsy walking ☐
- Numbness/tingling in hands/feet ☐

Pulmonary
- COPD/Asthma ☐
- Shortness of breath with exercise ☐
- Use of inhaler ☐

Other
- Vision/hearing difficulties ☐
- Poor tolerance to NSAIDS ☐
- Metal implants ☐
- Pregnant ☐

Constitutional symptoms
- Fever/chills/night sweats ☐
- Severe fatigue/malaise ☐
- Nausea/vomiting ☐
- Dizziness/fainting ☐
- Unexplained weight loss ☐

Immunologic
- HIV ☐
- HEP B, HEP C ☐

Food/Drug Allergies

Please list all food and drug allergies that you are aware of:

Surgeries/Hospitalizations

Please list recent hospitalizations, surgeries and any other medical information not listed above:

To the best of my knowledge, the information I provided above is accurate.

Signature: _____ **Date:** _____

Relationship to Patient: _____

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