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MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Next Dr Apt _____

Injury / Condition: _____ Surgery Date: _____ Onset Date: _____

Have you received physical therapy or Home Health Care via Medicare this year? Yes / No

Have you had any imaging performed for this condition? Please mark all that apply:

X-Ray CT Scan MRI Doppler Ultrasound Bone Scan

What did they show? _____

Have you recently noted:

Pregnant / IUD Numbness / Tingling Fatigue Change In Vision Or Hearing
 Nausea / Vomiting Weakness Headaches Fever / Chills / Sweats
 Pain At Night Weight Loss /Gain Insomnia Cramps In Legs When Walking

Do you have now or have you ever had any of the following?

Cancer – Type _____ Loss of Consciousness/Fainting Fractures
 Heart Problems / Pacemaker Diabetes Blood Pressure Problems
 Surgeries – list below Motor Vehicle Accident Allergies / Skin Sensitivity
 Sprains / Strains Seizures Hearing Difficulties
 Circulation Problems / Clots Asthma / Breathing Problems Lung Disease
 Easy Bruising / Bleeding Leg / Ankle Swelling Stroke
 Indigestion / Heartburn Urinary Problems / Infections NONE APPLY TO ME

Any previous injury that may affect current care: _____

Explain & give approximate dates for any items indicated above _____

Are you currently taking medications? Yes / No Attach list - or - Write Name or Type of Medication: _____

Current Pain Description

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other: _____

Rate your pain (average) on a 1-10 scale (1=minimal 10=severe) Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Treatment Goals

What do you hope to get out of your treatment? _____

Is there anything else you would like to include or ask your physical therapist? _____

Patient Signature