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Medical History Form

814 High St, Ste A, PO Box 368
Baldwin City, KS 66006
Phone: (785) 594-3162
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Patient Full Name: _____ Date of Birth: _____

Referring Physician: _____ Date of next doctor's appointment: _____

Please answer the following regarding your current condition:

What is the reason for your visit? _____ Date symptoms/injury began? _____

Check all that apply:

- work related injury recurrence of previous injury motor vehicle accident injury related to lifting
 athletic/recreational injury cause unknown other: _____

Have you ever had this or a similar injury before? Yes No If yes, please explain: _____

Medical History: Please check yes or no if you currently have or have ever had any of the following:

<p><u>DISEASES</u></p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/gout <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's disease <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Alzheimer's/Dementia <input type="checkbox"/> Yes <input type="checkbox"/> No Disease of the liver/gallbladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>NEUROLOGICAL</u></p> <p>Light headed or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent falls <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness/loss of sensation <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Memory loss or confusion <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke or TIA <input type="checkbox"/> Yes <input type="checkbox"/> No Head Injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>SPEECH LANGUAGE</u></p> <p>Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent choking or coughing while eating or drinking <input type="checkbox"/> Yes <input type="checkbox"/> No Speech difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty comprehending <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>MUSCULOSKELETAL</u></p> <p>Joint stiffness or swelling <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle weakness <input type="checkbox"/> Yes <input type="checkbox"/> No Joint pain <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle pain <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty in walking <input type="checkbox"/> Yes <input type="checkbox"/> No Recent fractures <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>RESPIRATORY</u></p> <p>Asthma or COPD <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath during activity <input type="checkbox"/> Yes <input type="checkbox"/> No Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>FUNCTIONAL CHANGES</u></p> <p>Decline in ability to perform ADLs - (dressing/bathing, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty standing up <input type="checkbox"/> Yes <input type="checkbox"/> No Decline in independence <input type="checkbox"/> Yes <input type="checkbox"/> No Decline in balance <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>CARDIOVASCULAR</u></p> <p>Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain/Angina <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No Congestive Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No Heart palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>VISION/HEARING</u></p> <p>Wear glasses/contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No Eye disease or injury <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of vision <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma/cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred or double vision <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing loss or injury <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aide <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in your ears <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Have you ever had surgery? Yes No If yes, please list: _____

Are you presently taking any medication? Yes No If yes, please list them along with dosage & frequency or attach a list.

Signature of person completing this form

Relationship to patient

Date

Thank you for choosing Lawrence Therapy Services!