

**MUSCATINE PHYSICAL THERAPY SERVICES, P.C.**  
2109 Cedarwood Drive, Suite 100, Muscatine, IA 52761 • 563-288-6787

**COLUMBUS JUNCTION PHYSICAL THERAPY**  
104 N. Main Street, Columbus Junction, IA 52738  
319-728-4441



**WEST LIBERTY PHYSICAL THERAPY**  
1103 N. Elm Street, West Liberty, IA 52776  
319-627-6809

*Let Our Strength Help You Regain Yours!*

**PATIENT MEDICAL HISTORY**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_  
please print

- 1. Is a Home Health Agency or Visiting Nursing Association currently seeing you? Yes No
- 2. Have you received any physical or occupational therapy this year? Yes No
- 3. If yes, where and when was this service provided? \_\_\_\_\_
- 4. In your own words, what is the problem that brought you here for therapy? \_\_\_\_\_
- 5. When did this problem start? \_\_\_\_\_

6. Do you have a past or present medical history of the following?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies            | <input type="checkbox"/> Yes <input type="checkbox"/> No Depression           | <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia               | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes             | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety              | <input type="checkbox"/> Yes <input type="checkbox"/> No Dizzy Spells         | <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinsons           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis            | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma               | <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures            | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer               | <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Speech Problems      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Condition    | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis            | <input type="checkbox"/> Yes <input type="checkbox"/> No Strokes              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker    | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency  | <input type="checkbox"/> Yes <input type="checkbox"/> No Incontinence         | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Circulation Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Problems      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Currently Pregnant   | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal Implants       | <input type="checkbox"/> Other _____  |

7. Fall History: Injury as a result of a fall in the past year? Yes No Two or more falls in last year? Yes No

8. Surgical History: Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date (MM/YY): \_\_\_\_\_

9. Current Medications: Drug(s) \_\_\_\_\_ Dosage \_\_\_\_\_ Reason taking \_\_\_\_\_  
Separate list provided Yes No

10. Is this a work related problem? Yes No If yes, please explain \_\_\_\_\_

11. Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_