Patient Medical Case History

Date:_____

Name:_____ Home Phone:_____ Work:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Please describe the history of your current problem over the past 6 months:_____

_____

What activities could you do before this problem that you cannot do now:_____

_____

What treatment have you had for this problem?_____

_____

Please check if you have a history of any of the following:

NEUROLOGICAL
___ Stroke/TIA
___ Brain Injury
___ Seizures/Epilepsy
___ Numbness/Tingling
___ Parkinson's
___ Dizziness/Vertigo
___ Severe Headaches
___ Coordination or balance problems
other: _____

ORTHOPEDIC
___ Fractures
___ Dislocations
___ Neck Pain/Injury
___ Back Pain/Injury
___ Arthritis
___ Osteoporosis
___ Joint Replacement
where:_____
other:_____
_____

CARDIAC/PULMONARY
___ Blood pressure High or Low (circle)
___ Heart Attack
___ Chest Pain
___ Irregular Heart Beat
___ Short of Breath
___ Asthma
___ Pacemaker/ Heart Device
other:_____

ONCOLOGY/ METABOLIC
___ Cancer
___ Thyroid Disease
___ Diabetes
___ Blood Clotting Disorder
___ Nausea/Vomiting
___ Immune Deficiency
other:_____

OTHER CONDITIONS
___ Vision/Hearing Loss (circle)
___ Impaired Speech/ Swallowing
___ Depression/Anxiety
___ Other Psychiatric Disorder
___ Claustrophobia
___ Memory Loss
other:_____

POOL/AQUATIC THERAPY PATIENTS
___ Fear of Water
___ Chlorine Sensitivity
___ Open Wound/Rash
___ Bladder/Bowel Control Problems
___ Ear Drum Injury
other:_____
_____

Current Medications: ☐ See List
_____
_____
_____
(May use back of page)

Do you have any allergies? No___ Yes_____
(please list)_____
_____

Next appointment with referring doctor: _____
Is this case under litigation? No ___ Yes _____

*Patient Signature:*_____
Date:_____

(label)