REVIVE
Physical Therapy & Wellness

Diane Shiao MSPT, DPT
1941 Oak Tree Rd.
Ste #302
Edison, NJ 08820
P (732) 662-7927
F (732) 662-7928
info@revivephysicaltherapy.com

Medical History Form

Name: _____ DOB: _____ Date: _____

Reason for Visit: _____

Date symptoms began: _____

Occupation: _____ Last date worked due to injury: _____

Is there any attorney involved? Y N If yes, name of Attorney: _____

Do you have any of the following conditions?

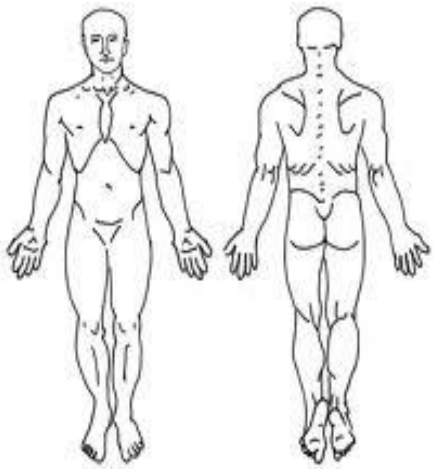
Migraine Headaches □ Yes □ No	Do you have a pacemaker? □ Yes □ No	Weight / Energy Loss or Gain □ Yes □ No	Hernia □ Yes □ No
High Blood Pressure □ Yes □ No	Lung problems, Asthma, Emphysema □ Yes □ No	Numbness in Legs or Arms □ Yes □ No	Multiple Sclerosis / Parkinson's □ Yes □ No
Dizziness / Fainting □ Yes □ No	Cancer □ Yes □ No Type: _____	Numbness in Genital Region □ Yes □ No	Latex Sensitivity / allergy □ Yes □ No
Epilepsy / Seizures □ Yes □ No	Infectious Disease □ Yes □ No	Sleeping problems / Difficulty □ Yes □ No	Diabetes □ Yes □ No 1 or 2
Strokes / TIA □ Yes □ No	Pain with Coughing or Sneezing □ Yes □ No	HIV / AIDS □ Yes □ No	Females: Are you pregnant? Y N
Pins or Metal Implants □ Yes □ No	Osteoporosis / Osteopenia □ Yes □ No	Bowel or Bladder Problems □ Yes □ No	Any additional comments?
Blood Clot / Emboli □ Yes □ No	Rheumatoid Arthritis □ Yes □ No	Sensitivity to Heat or Cold □ Yes □ No	
Heart Problems □ Yes □ No	Degenerative Arthritis □ Yes □ No	Allergies □ Yes □ No	

How would you grade your pain level? Please circle a "high" or "low" ranking:

0 1 2 3 4 5 6 7 8 9 10

0: Pain-free 1-3: Mild 4-6: Moderate Pain 7-10: Severe Pain

Using the figure on the right: mark XXXX on the areas with pain, ====
on the areas with numbness, and 0000 on the areas with pins and needles.



Please list your current medications:

_____

_____

Please list allergies: _____

_____

Please list previous surgeries/hospital conditions:

_____

_____

Please describe any past or present joint injuries or diseases:

_____

Please describe your current occupation and job duties that you are currently unable or having difficulty performing due to your symptoms: _____

_____

Please describe any current social or physical activities that you have limited or stopped due to your symptoms:

_____

The above information is correct to the best of my knowledge. **Signature of Patient:** _____