

ALASKA PHYSICAL THERAPY SPECIALISTS P.C.

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PATIENT MEDICAL HISTORY

Name: _____ CHART # _____

Referring Doctor: _____

Have you had surgery for this injury? YES NO

Type of surgery: _____

Are you currently taking any prescription medications? YES NO

List medications: _____

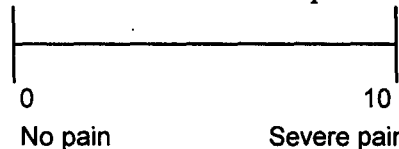
Is this a work / auto injury? Date of injury _____

List any information or health concerns that would assist us in your care.

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

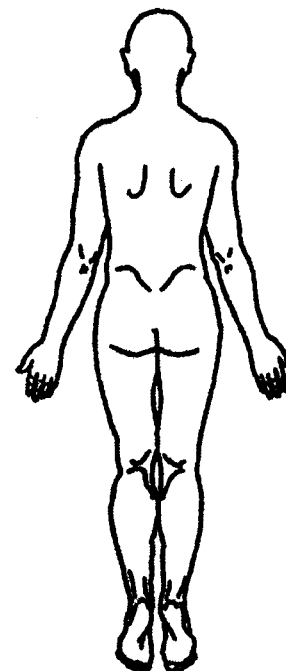
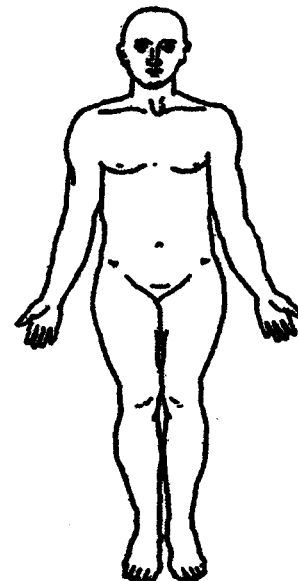
- | | | |
|------------------------------------|-----------|----------|
| Asthma, bronchitis, or emphysema | yes _____ | no _____ |
| Shortness of breath / chest pain | yes _____ | no _____ |
| Coronary heart disease | yes _____ | no _____ |
| Do you have a pacemaker? | yes _____ | no _____ |
| High blood pressure | yes _____ | no _____ |
| Heart attack/ heart surgery | yes _____ | no _____ |
| Stroke / TIA | yes _____ | no _____ |
| Congestive heart disease | yes _____ | no _____ |
| Blood clot / emboli | yes _____ | no _____ |
| Epilepsy / seizures | yes _____ | no _____ |
| Anemia | yes _____ | no _____ |
| Infectious diseases | yes _____ | no _____ |
| Diabetes | yes _____ | no _____ |
| Cancer / chemotherapy / radiation | yes _____ | no _____ |
| Arthritis | yes _____ | no _____ |
| Osteoporosis | yes _____ | no _____ |
| Sleeping problems or difficulties | yes _____ | no _____ |
| Emotional / Psychological problems | yes _____ | no _____ |
| Increased stress | yes _____ | no _____ |
| Severe or frequent headaches | yes _____ | no _____ |
| Vision / hearing difficulties | yes _____ | no _____ |
| Spinal Surgery | yes _____ | no _____ |
| Numbness or tingling | yes _____ | no _____ |
| Dizziness or fainting | yes _____ | no _____ |
| Bowel or bladder problems | yes _____ | no _____ |
| Weakness | yes _____ | no _____ |
| Weight loss / Energy loss | yes _____ | no _____ |
| Allergies | yes _____ | no _____ |
| Pins or metal implants | yes _____ | no _____ |
| Joint replacement surgery | yes _____ | no _____ |
| Are you pregnant? | yes _____ | no _____ |
| Do you use tobacco? | yes _____ | no _____ |

Please indicate current pain level



Please indicate what type of pain and where

- ↑ SHARP PAIN
- + NUMBNESS/TINGLING
- * BURNING
- ACHING



Patient / Guardian Signature

Date