



# MI Therapy Clinic

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## MEDICAL HISTORY

Patient Name

Date

### 1. Diagnosed conditions — check all that apply

- |                       |                               |                      |
|-----------------------|-------------------------------|----------------------|
| Heart Problems        | High Blood Pressure           | Rheumatoid Arthritis |
| Headaches             | Hepatitis                     | Stroke               |
| Respiratory Problems  | HIV / AIDS                    | Fractures            |
| Rheumatic Fever       | Endocrine Disorder            | Tuberculosis         |
| Diabetes              | Stomach / GI Problems         | Anxiety              |
| Kidney Disease        | Multiple Sclerosis            | Hernia               |
| Peripheral Neuropathy | Cancer                        | Congenital Disorder  |
| Asthma                | Head / Neck Injury            | Blood Disorder       |
| Osteoporosis          | Dizzy / Fainting Spells       | Epilepsy / Seizures  |
| Parkinson's Disease   | Circulatory Disorder          | Chest Pain / Angina  |
| Anemia                | Depression / Nervous Disorder | Allergies            |

Fracture / Cancer location

### 2. Prior or recent surgeries

3. Are you currently pregnant?                      Yes              No              N/A

4. Current medications (name, dose, frequency)

5. Current pain level (0 = best, 10 = worst)

6. Sad, depressed, or lost interest in past 6–12 months?

Yes              No

7. Do you have:                      Pacemaker                      Metal Implants                      Cardiac Stents



## MEDICAL HISTORY — CONTINUED

### 8. Symptoms and pain details

Location of pain, numbness, or tingling — describe in detail

9. Since onset, are your symptoms: Better Worse Not changing

10. Type of pain — check all that apply

<input type="checkbox"/> Throbbing	<input type="checkbox"/> Sharp	<input type="checkbox"/> Aching	<input type="checkbox"/> Tingling	<input type="checkbox"/> Burning
<input type="checkbox"/> Numbness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Dull	<input type="checkbox"/> Constant	<input type="checkbox"/> Occasional

11. As the day progresses, do your symptoms: Increase Decrease Stay the same

### Daily activity and previous care

12. Activities that increase your symptoms

13. What relieves your symptoms

14. Have you had treatment for this condition before? Yes No

15. Tests received for this problem

<input type="checkbox"/> X-ray	<input type="checkbox"/> MRI	<input type="checkbox"/> CT Scan
<input type="checkbox"/> EMG	<input type="checkbox"/> Bone scan	<input type="checkbox"/> Nerve conduction

Other tests / results

16. Goals and expectations for physical therapy

### Patient Authorization

I certify the information above is accurate to the best of my knowledge.

Patient Signature

Date

### Therapist Use Only

Therapist Signature

Date