AGAPE therapy
REHAB RESTORE RECLAIM

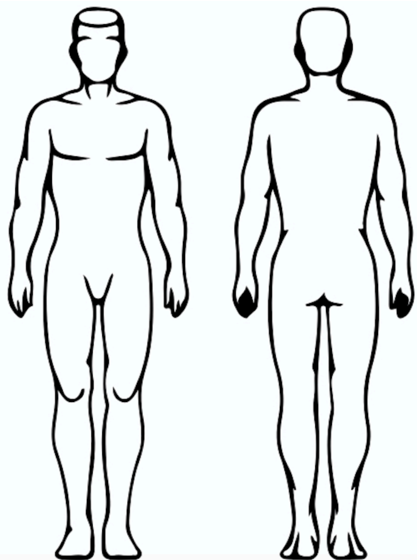
PATIENT MEDICAL HISTORY FORM

(please fill out thoroughly)

Name	Gender	Today's Date	Birthdate	Emergency Contact and Phone #
Address	Email		Cell Phone	Patient Employer: Duty: ☐ PT ☐ FT
Doctor Name Doctor Location	**Have you had therapy anywhere this year?** ☐ yes ☐ no If yes: # of visits _____ **Are you getting in home care?** ☐ yes ☐ no			**Is this condition:** 1. Fall related? ☐ yes ☐ no 2. Automobile related? ☐ yes ☐ no 3. Work related? ☐ yes ☐ no

How do you learn best? ☐ hearing ☐ seeing ☐ doing	**Do you have difficulty:** ☐ hearing ☐ seeing ☐ speaking ☐ reading
How did you hear about us? (circle) ☐ doctor referred (write name): ☐ tv commercials ☐ drive by ☐ been here before ☐ friend ☐ other:	

WHAT IS YOUR CURRENT CONDITION/ISSUE?____



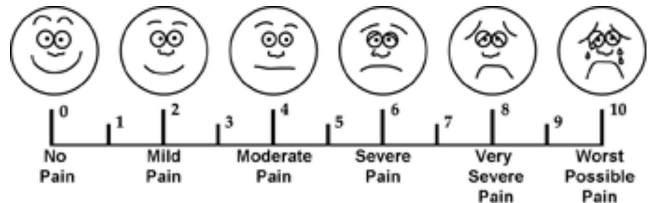
Is this the first episode?
☐ yes ☐ no If no, when was the first episode?

Symptoms start date:

Symptoms are:
☐ constant ☐ intermittent ☐ chronic ☐ new
☐ getting better ☐ getting worse ☐ same

Where is your pain?
← Mark on the person where your pain is and note type of pain.

Pain Intensity:
____/10 current
____/10 at best
____/10 at worst



Pain gets better:
☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

Pain gets worse:
☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

What is limited because of current complaint:
☐ sleep ☐ self-care ☐ housework ☐ reaching ☐ lifting ☐ sitting ☐ standing ☐ bending ☐ community access ☐ work

Sleep position:
☐ back ☐ belly ☐ right side ☐ left side ☐ recliner ☐ restless ☐ other:

Any other notes:

-MEDICAL HISTORY-

(Please fully answer these questions; you would be surprised how this helps us to help you!)

Other Recent Symptoms		
Have you recently noted any of the following? (check all that apply)		
Extreme fatigue	Anxious or down	Shortness of breath
Constipation/diarrhea	Dizziness/light headed	Numbness/tingling
Visual changes	Muscle weakness	Heartburn/indigestion
Incontinence	Bowel/bladder changes	Unexplained cough
Fainting	Unexplained weight gain/loss	Swelling
Nausea/vomiting	Rapid heart rate/palpitations	Brain fogginess
Fever/sweats/chills	Recent onset of headaches	Other:

Past Diagnosis(s)		
Have you ever been diagnosed with any of the following? (check all that apply)		
Cancer	Asthma	Bladder/urinary/kidney
Diabetes I or II	Thyroid condition	GI disease
Cardiovascular	Bone/joint infection	Depression/anxiety
Respiratory	Seizures	Neurological disease
Vascular(Strokes, etc)	Chronic headaches	Visual/hearing impairments
Infectious disease(s)	Arthritis	High/low blood pressure
TB/HIV/Hepatitis	Chest pain	Other:

Please list ALL	
Surgeries/injections.	
Imaging. Check and date:	☐ Xray ☐ CT Scan ☐ MRI ☐ other:
Other practitioners you have seen for treatment:	
Falls or traumas:	
Do you have allergies to:	☐ latex ☐ cold ☐ heat ☐ medications Any other allergies?

Family History in regard to current condition: (relationship to patient and condition)

List current medications/vitamins/supplements: You can bring in a document containing this if you wish.

Name *Purpose*

Health Considerations:

Smoking:	☐ currently	☐ history	
Alcohol:	☐ currently	☐ history	__drinks/week
Pregnancy:	☐ currently	__# of weeks along	__# of total pregnancies

To the best of my ability, I have included all pertinent medical information. I also give consent to receive therapy by qualified staff and/or participate in fitness or physical activity opportunities.

Patient/Guardian Signature: ______________________________ Date: ______________

-Agape thanks you for your completeness; we promise it will help give you great care!