Print Form

JOHNSON MEMORIAL Hospital
A HOSPITAL YOU CAN BELIEVE IN
1125 West Jefferson Street
PO Box 549
Franklin, IN 46131
(317)736-3510
Fax (317) 346-3727

Best Contact Phone #_____ Date_____

Occupation:	Currently working: ☐ No ☐ Yes	Total work days missed	Date of injury/onset	Employer	Date of surgery

Condition due to : ☐ Auto Accident ☐ Illness ☐ Work comp ☐ Other

Job or Activity Restrictions	Date of next appt with MD

Check any of the following providers that you have seen for this condition:

☐ Orthopedic surgeon ☐ Chiropractor ☐ Physical/Occupational Therapist ☐ Home Health Agency
☐ Neurosurgeon ☐ Physiatrist ☐ Psychiatrist/Psychologist
List others_____

Check Diagnostic Tests done for your current condition:

☐ Xray ☐ MRI ☐ EMG ☐ CAT Scan ☐ Bone scan ☐ Bone density ☐ Lab work (blood, urine, etc)
List others_____

Check any medical issues that you have had or currently have:

☐ Diabetes
☐ Pacemaker
☐ Heart condition
☐ High blood pressure
☐ Cancer
☐ Stroke
☐ Parkinson's
☐ Breathing problems
☐ Dizziness
☐ Fainting/blackouts
☐ Migraine/headaches
☐ Seizure/Epilepsy
☐ Currently pregnant
☐ Depression
☐ Arthritis
☐ Osteoporosis
☐ Night sweats
☐ Sores not healing
☐ Bleeding disorders
☐ Nutritional concerns
☐ Pelvic Pain
☐ Unexpected weight loss/gain
☐ Lumps/thickening of skin or muscle
☐ Recent illness (colds, influenza, infection)
☐ Urinary/Fecal Incontinence
☐ IBS
☐ Smoking history
_____ packs per day month year

List others_____

Check any previous Surgeries:

☐ Head ☐ Back ☐ Arm ☐ Wrist/Hand ☐ Leg ☐ Abdominal
☐ Neck ☐ Shoulder ☐ Elbow ☐ Hip ☐ Ankle/Foot ☐ Hysterectomy
☐ Knee ☐ Heart ☐ C-section

List others_____

Check current Medication types:

☐ Anti-inflammatories ☐ Pain medication ☐ Muscle relaxants ☐ Osteoporosis medication
☐ Diuretics ☐ Vestibular suppressants ☐ Anti-depressants ☐ Hypertension/Blood Pressure
☐ Blood thinner ☐ Cortisone/Steroids ☐ Diabetic ☐ Epidural/Trigger Point Injections

List medications _____

_____

Check Allergies: ☐ Latex ☐ Sulfa ☐ Cortisone ☐ Penicillin ☐ Food ☐ Environmental ☐ Adhesives

List others_____

Is there anything that would limit your ability to return for follow up visits? ☐ No ☐ Yes _____

Is there anything that would limit your ability to learn? ☐ No ☐ Yes _____

How did your injury/symptoms occur?_____

_____

Who referred you to PT?_____ Primary physician_____

Are your symptoms: ☐ Constant? ☐ Intermittent?
Are your symptoms: ☐ Getting better? ☐ Getting worse? ☐ Staying the same?

What makes your symptoms better?_____

MR Form 3474202

PT OUTPATIENT MEDICAL HISTORY

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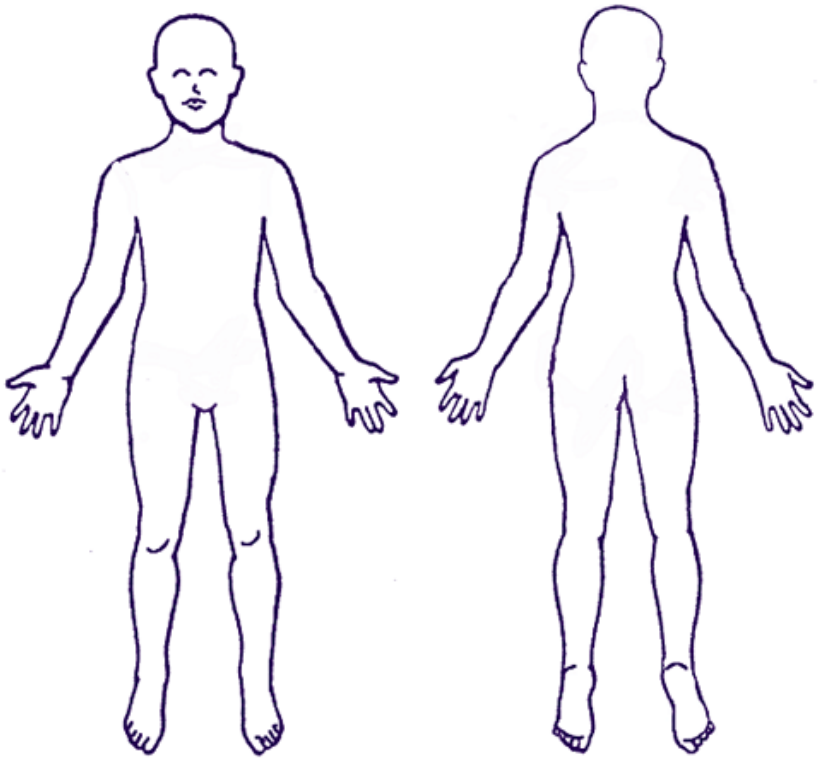
Mark an X on the scale where it best describes your pain

0	1	2	3	4	5	6	7	8	9	10
No pain	Barely noticeable				Need to stop doing what you are doing			Can't get out of bed		In the ER

Indicate on body diagrams where your symptoms are located: • Pain III Numbness



What do you expect to accomplish with physical therapy? (Goals)_____

_____

Patient Signature:_____Date_____Time_____

Reviewed By:_____Date_____Time_____

MR Form 3474202a

PT OUTPATIENT MEDICAL HISTORY