General Medical History Form

Name _____ Date_____

What brings you to our office today?

_____

_____

How long has the problem been present? _____

How did it start? Was there an injury or obvious cause? _____

_____

Have you been seen by your doctor for a face to face visit for this specific issue? YES NO

Which Doctor? _____ Appointment Date? _____

Has any treatment been received? YES NO If yes please circle one or more

Medication Surgical Physical Therapy Chiropractic None Other

Please describe: _____

_____

Did the treatment help your issue? _____

Is there any joint swelling? YES NO Is there any joint Stiffness? YES NO

Is there any difficulty with balance and coordination or frequent falling? YES NO

Are you experiencing any pain? _____ on a scale of 1-10 (10 being most painful)

When is pain most likely to occur? Morning Evening Constant Intermittent

What relieves the pain? _____

Please check if you have had, or currently have any of the following:

- ○ Amputation
- ○ Arthritis
- ○ Drop Foot
- ○ Fractures
- ○ Diabetes
- ○ Epilepsy
- ○ Heart Disease
- ○ Hepatitis
- ○ HIV/Aids
- ○ Cerebral Palsy
- ○ Brain/Spinal Injury
- ○ Muscular Dystrophy
- ○ Multiple Sclerosis
- ○ Spina Bifida
- ○ Charcot Joint
- ○ Charcot Marie Tooth
- ○ Club Foot
- ○ Muscle or Tendon Tear
- ○ Osteoporosis
- ○ Parkinson's Disease
- ○ Pinched Nerve
- ○ Polio
- ○ Psychiatric Care
- ○ Rheumatoid Arthritis
- ○ Stroke
- ○ Tumors or Growths
- ○ Ulcers (foot/leg)

Assistive Devices Used: (circle) Cane Walker Crutches Wheelchair No Device

Living Conditions: (circle) Level Surfaces Ramp Uneven Surfaces Stairs How many? _____

Will you have help applying the orthosis or prosthesis? YES NO

Are currently doing Physical Therapy? YES NO Where? _____

Have you ever worn an orthosis (brace) or prosthesis? YES NO If yes, please describe what type and date received. _____

Describe your orthotic/prosthetic history and current problems to resolve: _____

_____

What are your goals upon receiving a new device? _____

_____

Current or expected types of general activities (Circle all that apply)

Walking Running Stairs Household Chores Hiking Golf Driving
Exercise Hunting Fishing Gardening Lawn Care Use of stairs/ladder

Other: _____

Patient Signature _____ Date_____