MAXUM Therapy
Physical • Occupational • Speech

Patient Medical History

Last Name: _____ First Name: _____ MI: _____

Date of Injury: _____ How did the injury occur? _____

Have you had previous therapy for this condition? (please circle) **yes / no**

Medical History

Have you had any of the following (circle yes or no; if yes please answer the additional questions)

Blood Pressure Problems	yes / no	Dizziness	yes / no
Heart Trouble	yes / no	Vision Problems	yes / no
Diabetes	yes / no	Cancer: Where?	yes / no
Headaches	yes / no	Difficulties with bowels or bladder?	yes / no
Metal Implants: Where?	yes / no	Pacemaker	yes / no
Pregnancy: When?	yes / no	Unexpected Weight Change (≥ 10 lbs)	yes / no

Please list any other illnesses or conditions not mentioned above: _____

List any surgeries and their dates: _____

Are you currently taking any medication? (Please circle) **yes / no**

If yes, what are they? _____

Daily Activities

Do you have pain or problems with the following activities? (circle yes or no; if yes, please specify as indicated)

Walking: How long?	yes / no	Reaching Overhead	yes / no
Standing: How long?	yes / no	Reaching Backward	yes / no
Running: How long?	yes / no	Lifting	yes / no
Sitting: How long?	yes / no	Dressing	yes / no
Bending Forward	yes / no	Washing you hair	yes / no
Bending Backward	yes / no	Turning your head	yes / no
Sleeping: How long?	yes / no	Grasping items with your hand	yes / no