FOX VALLEY PHYSICAL THERAPY
& WELLNESS CLINIC
STEVEN SOBOJINSKI, OTR, CSCS • REGINA SOBOJINSKI, PT
909 S. Washburn St., Oshkosh, WI 54904 • ph. 920.235.8966 • fax 920.235.1526

Medical History

Date: _____

Name: _____ Date of Birth: _____

Referring Physician: _____

Diagnosis (reason for referral): _____

Have you seen any of the following for your current injury or condition?
___ Medical Doctor ___ Physical/Occupational Therapist (or have you had therapy in your home) ___ Chiropractor

Have you had surgery for the current condition? ___ Yes ___ No
If so when: _____

Have you received injections for the current condition? ___ Yes ___ No
Did it help: _____

Have you been diagnosed with any of the following? If so list when and current status. ___ Yes ___ No
Arthritis_____ Cancer_____
Stroke_____ Pacemaker_____
Diabetes_____ High/low blood pressure_____
Pregnant (currently)_____ Heart Condition _____
Other conditions _____

Have you had any diagnostic testing done for this condition? If yes check which ones. ___Yes ___ No
___ X ray ___MRI ___CT ___EMG Other_____

Are you taking any medications for the current condition? ___ Yes ___ No
If yes please list: _____

Are there any other medications you are taking? ___ Yes ___ No
If yes please list: _____

Are you currently in pain? ___ Yes___ No Pain Scale: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Nature: constant / intermittent / localized / radiating
Where is your pain located? _____
What makes your pain worse? _____
What makes your pain better? _____
When did your pain begin? _____
How did your pain/injury occur? _____

When do you return to your doctor? _____

What is your occupation? _____

Who is your employer? _____

What is your work status?
___ Full Duty ___ Restricted Duty ___ Off Duty Hours per week _____

How did you hear of our services? _____

What do you hope to accomplish through physical therapy? _____