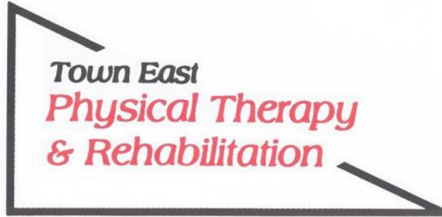

MEDICAL HISTORY

Patient Name ______________________________________

Reason for therapy or testing

____

____

Date of injury or onset ____

Diagnostic tests and results

____

____

Previous treatment received (what, when, where ?)

Physical Therapy ____

Surgery ____

Other ____

Check any and all conditions listed below that you now have or ever had.

__ High blood pressure	__ Migraine headaches	__ Arthritis
__ Diabetes	__ Heart disease	__ Pacemaker
__ Vascular disease	__ Open wounds	__ Current infections
__ Current flu or fever	__ Hernia	__ Current pregnancy
__ Osteoporosis	__ CVA / stroke	__ Seizures
__ Cancer	__ Fractures	__ Depression

Date and details of any conditions listed above, or about conditions not listed:

____

____

____

Are you taking any of the following medications (yes / no)?

Anti-inflammatory _______

Pain reducer _______

Who is your Primary Care Physician?

Name ____________________________ Phone # ____________________

Patient / Parent / Guardian signature ____________________________________ Date _______________

Therapist's initials after review of information ___________________________ Date _______________