

PATIENT'S PAST MEDICAL HISTORY

(Please print, fill out, and bring on your first visit.)



Patient's name: _____ Age: _____

Please circle all that apply:

Have you ever suffered from:			Date of onset and current status
Anemia	Yes	No	
Angina / Chest pain	Yes	No	
Arthritis	Yes	No	
Cancer	Yes	No	
Diabetes	Yes	No	
Headaches	Yes	No	
Head Injury	Yes	No	
Heart Disease	Yes	No	
High Blood Pressure	Yes	No	
Kidney Disease	Yes	No	
Mental Health Problems	Yes	No	
Neuropathy	Yes	No	
Osteoporosis	Yes	No	
Pacemaker	Yes	No	
Respiratory Problems:	Yes	No	
Asthma	Yes	No	
Emphysema	Yes	No	
Shortness of breath	Yes	No	
Chronic bronchitis	Yes	No	
Other:	Yes	No	

1. Please state injury/condition requiring physical therapy and date of onset _____

(Continued next page)

PATIENT'S PAST MEDICAL HISTORY

(Continued)



2. Is pain an issue? Yes _____ No _____

If "yes," please rate your pain on a scale from 0 to 10 (0 no pain; 10 the worse possible pain)

3. Have you had any recent MRIs, CAT scans or X-rays? If "yes," when? _____

Please provide us with a copy of the report from your physician.

4. Have you been treated for the same problem before? Yes _____ No _____

If "yes," what was the treatment you received, and was it successful? _____

5. What medications are you currently taking? _____

6. Please list surgical history with dates: _____

7. What are your current physical activities? _____

8. List your specific goals and your expectations from physical therapy. _____

9. How did you find out about us?

Doctor _____

Friend/Prior patient _____

Our website _____

Other _____

Signature: _____ Date _____