Medical History

Name: _____ _____ _____ Date: _____/ _____/ _____
Last Name Middle Initial First Name

DOB: _____/ _____/ _____ Age: _____ Race: _____ Gender: **M** **F**

SSN#: _____ - _____ - _____ Referring Physician: _____

Reason for Therapy: _____ Have you had physical therapy before? Yes No

Do you have any allergies (drug or other)?

_____

_____

_____

_____

Do you react to heat/ cold applications or Latex? **Yes** **No**
*If yes, check all that apply

- ☐ Swelling
- ☐ Sweating
- ☐ Skin Discoloration
- ☐ Shortness of Breath
- ☐ Pain
- ☐ Nausea
- ☐ Increased Blood Pressure
- ☐ Excessive Chills
- ☐ Other: _____

Please check any of the following condition you have or have had:

- ☐ Anemia
- ☐ Asthma
- ☐ Asthma(exercised induced)
- ☐ Blood Clots
- ☐ Broken Bones/ Fractures
- ☐ Cancer
- ☐ Cardiac/ Heart Conditions
- ☐ Diabetes
- ☐ Degenerative Joint Disease (ex. Arthritis)
- ☐ Dizziness or Fainting
- ☐ Epilepsy/ Seizures
- ☐ Head Aches
- ☐ Head Injury
- ☐ Hearing Problems
- ☐ Hypertension
- ☐ Metal Implants or Pins
- ☐ Neurological Disease: Parkinson's, Multiple Sclerosis
- ☐ Numbness/ Tingling in Arms/ Legs
- ☐ Vision Problems
- ☐ HIV
- ☐ AIDS
- ☐ Other Infectious Disease

Do you use tobacco? ☐ Yes ☐ No- Never used ☐ No- Quit more than one year ago ☐ No- Quit less than a year ago

Are you having difficulty with:

- ☐ Caring for Self
- ☐ House Work
- ☐ Shopping
- ☐ Sleeping
- ☐ Social Activities
- ☐ Yard Work
- ☐ Working
- ☐ Other: _____

Injuries/ Surgeries (List date & type of injury/ surgery):

Date/ Year:	Injury /Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Check/ List any Medications that you are currently taking:

- ☐ Advil
- ☐ Aleve
- ☐ Celebrex
- ☐ Darvocet
- ☐ Hydrocodone
- ☐ Ibuprofen
- ☐ Motrin
- ☐ Naprosyn
- ☐ Tylenol
- ☐ Tylenol PM
- ☐ Relafen
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

List any herbals or vitamins that you are currently taking:

Herbals:	Vitamins:
_____	_____
_____	_____
_____	_____
_____	_____

Please list anything else we need to be aware of:

_____

_____

_____

Patient Signature: _____

Date: _____/ _____/ _____

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