MEDICAL HISTORY FORM

NAME: _____ DATE: _____
REFERRING PHYSICIAN: _____ DATE OF BIRTH: _____
FAMILY PHYSICIAN: _____

MEDICAL HISTORY

Is your current condition related to an injury? **Yes___** **No___**
If YES, was the injury related to: **Auto___** **Work___** **Other___** **Date of Injury** _____

Have you received physical/speech therapy in the last year? **Yes___** **No___**

If YES, refer to your insurance policy for limitations.

Please check any of the following conditions you have or may have had in the past:

_____ Heart Disease	_____ Tuberculosis	_____ Asthma
_____ High Blood Pressure	_____ Currently Pregnant	_____ Stroke
_____ Heart Murmur	_____ Fatique/Energy Loss	_____ C.O.P.D.
_____ Mood Disorders	_____ Chest Pain/Discomfort	_____ Hepatitis
_____ Shortness of Breath	_____ Ankle Swelling	_____ Anemia
_____ Kidney Disease	_____ Epilepsy/Seizures	_____ Diabetes
_____ Dizzy Spells	_____ Allergies	_____ Hernia
_____ Headaches	_____ Cancer: Type_____	
_____ Loss of Bladder/Bowel Control	_____ Other: _____	

ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

_____ Osteoporosis	_____ Scoliosis
_____ Broken Bones	_____ Sprains/Strains
_____ Arthritis	_____ Balance/Walking Problems
_____ Fibromyalgia	_____ Limited Range of Motion
_____ Slipped/Ruptured Disc	_____ Subluxed/Dislocated Joints
_____ Weakness	_____ Painful Grinding/Cracking in a Joint
_____ Compression Fractures	

Have you had a recent: X-Ray____ MRI____ CT Scan____
If so, when? _____ _____ _____

Please list hospitalizations or surgeries you have had in the last five years, including dates:

_____

_____

Please list any medications you are currently taking:

_____

Are you allergic to any medications: Yes____ No____ If yes, please list: _____

Signature: _____ Date: _____
PT Signature: _____ Date: _____