



MEDICAL HISTORY FORM

NAME: _____
 REFERRING PHYSICIAN: _____
 FAMILY PHYSICIAN: _____

DATE: _____
 DATE OF BIRTH: _____

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 _____

Are there any lawsuits pending regarding your condition? Yes___ No___

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:

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fatigue/Energy Loss | <input type="checkbox"/> C.O.P.D. |
| <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Chest Pain/Discomfort | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Cancer: Type _____ | |
| <input type="checkbox"/> Loss of Bladder/Bowel Control | <input type="checkbox"/> Other: _____ | |

ORTHOPEDIC LIMITATIONS

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

- | | |
|--|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Balance/Walking Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Limited Range of Motion |
| <input type="checkbox"/> Slipped/Ruptured Disc | <input type="checkbox"/> Subluxed/Dislocated Joints |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Painful Grinding/Cracking in a Joint |
| <input type="checkbox"/> 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: _____