



Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth _____ Age _____

Have you had PT, *within the current year*, for the condition you are coming in for today? Yes _____ No _____
If yes, where? _____

What are your goals of Physical Therapy? (ie: walk/run, garden, walk up/down stairs)

1. _____
2. _____
3. _____

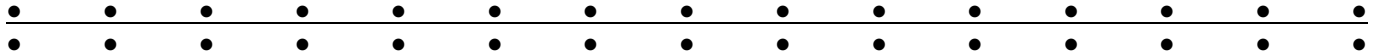
What is your occupation? _____ Are you currently working? Yes _____ No _____

Work Status: FT _____ PT _____ Retired _____ Student _____ Disabled _____

Do you have any work restrictions? Yes _____ NO _____ If yes, please indicate: _____

Present Activity level: Sedentary _____ Light _____ Heavy _____ Very Heavy _____

Hobbies/Recreational Activities _____



Past Surgery(s) and dates: 1. _____
 2. _____
 3. _____
 4. _____

Do you have any of the following conditions?

High Blood Pressure: _____ Yes ___ No	Respiratory Ailments: _____ Yes ___ No	Describe: _____
Heart Disease: _____ Yes ___ No	Allergies: _____ Yes ___ No	Describe: _____
Heart Pacemaker: _____ Yes ___ No	Metal Implants: _____ Yes ___ No	Where: _____
Diabetes: _____ Yes ___ No	Cancer: _____ Yes ___ No	Where: _____
Jaw Clicking or Pain: _____ Yes ___ No	Arthritis: _____ Yes ___ No	Describe: _____
Bowel/Bladder Changes: _____ Yes ___ No	Muscle/Joint Pain: _____ Yes ___ No	Describe: _____
Nausea: _____ Yes ___ No	Currently pregnant: _____ Yes ___ No	Due Date: _____
Headaches: _____ Yes ___ No	History of Falls: _____ Yes ___ No	Number/When: _____
Dizziness: _____ Yes ___ No		

Do you have any other medical conditions that might be affected by your physical therapy treatment that we should be aware of?
If so, please explain: _____

List Medications (or provide a list):

Have you had any of the following due to your current condition?

X-Rays: _____ Yes ___ No Results _____
 M.R.I.: _____ Yes ___ No Results _____
 CT Scan: _____ Yes ___ No Results _____