Wilson Physical Therapy, S.C.
Soo Line Depot Building
400 3rd Avenue West, Suite 100
Ashland, WI 54806-1610

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 _____