



Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for therapy: \_\_\_\_\_

Current medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Do you have any previous history of: (please circle yes or no and explain, providing approximate dates)

Yes No Heart Condition/Heart Attack \_\_\_\_\_

Yes No Stroke \_\_\_\_\_

Yes No Diabetes \_\_\_\_\_

Yes No Asthma \_\_\_\_\_

Yes No High Blood Pressure \_\_\_\_\_

Yes No Cancer \_\_\_\_\_

Yes No Anemia \_\_\_\_\_

Yes No Seizures/Epilepsy \_\_\_\_\_

Yes No Severe/Chronic Headaches \_\_\_\_\_

Yes No Arthritis \_\_\_\_\_

Yes No Pacemaker \_\_\_\_\_

Yes No Osteoporosis \_\_\_\_\_

Yes No Kidney Disease \_\_\_\_\_

Yes No Hepatitis/Jaundice \_\_\_\_\_

Yes No Loss of Hearing \_\_\_\_\_

Yes No Circulatory Problems \_\_\_\_\_

Yes No Recent Weight Loss/Gain \_\_\_\_\_

Yes No Dizziness/Loss of balance \_\_\_\_\_

Yes No Incontinence \_\_\_\_\_

Yes No Is there any chance you may be pregnant at this time? If Yes, Due Date: \_\_\_\_\_

During the past 5 years have you: (please circle yes or no and explain)

Yes No Been admitted to hospital or had surgery? \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Yes No Had any previous orthopedic problems or injuries? \_\_\_\_\_

Yes No Received any physical therapy treatments? For what condition(s)? \_\_\_\_\_

Regarding the condition that brings you here today: (please circle yes or no and explain)

Yes No Are you currently receiving treatments from another medical provider? (ie. Home health, chiropractic, etc.) \_\_\_\_\_

Yes No Have you had any special medical tests or studies? (ie. X-Ray, MRI, etc.) \_\_\_\_\_

\_\_\_\_\_  
Patient signature and date

\_\_\_\_\_  
Therapist signature and date