



PAST MEDICAL HISTORY FORM

Patient Name: _____

Date: _____

Are you presently working? Yes No

Date of next physician's visit: ___/___/___

Date of injury / onset: ___/___/___ Have you ever had physical therapy for these symptoms before? Yes No

Check which apply to your symptoms:

- work related injury
- recurrence of previous injury
- motor vehicle accident
- injury related to lifting
- cause unknown
- athletic / recreational injury
- injury related to falling
- other: _____

Have you had a related surgery? Yes No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Poor tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heat Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/ Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>

If yes on any of the above, please briefly explain and give approximate date:



Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? Yes No

If yes, please list what medications and for what condition:

In case of an emergency, whom should we contact?

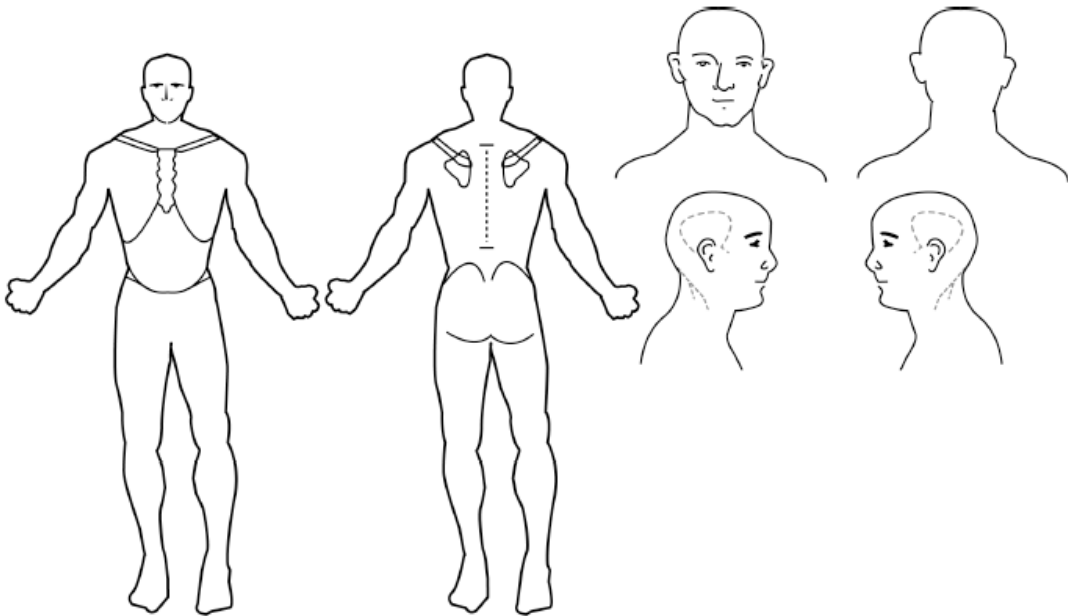
Name: _____

Phone Number: _____

Do you participate in any sports, exercise programs or activities on a regular basis? Yes No

If yes, please describe _____

Please indicate below where your symptoms are located.



If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.



Patient's Signature Date / / Signature of Guardian if patient is a minor

Therapist Signature Date / /