First Name: ________________________ Last Name: ___________________________

Sex: F____/M___ Date of Birth: (MM) ___/ (DD) ___/ (YYYY) ______

Diagnosis/Reason for Therapy: ___________________ Onset Date: ___________________________

Have you previously received therapy for this condition? Y/N. If yes, when? _____________________

Have you had any other physical therapy treatment(s)? Y/N. If yes, for what condition and when?

__________________________ ____________________________________________________________

Are you generally in good health? Y/N. If not, please specify condition: ___________________________

**For our female patients:** Are you or could you be pregnant? Y/N. If yes, specify term: _____________

**Do you have, have had or ever been diagnosed with any of the following conditions?**

| | YES | NO |
|---|---|---|
| Anemia | | |
| Anxiety | | |
| Arthritis (specify) | | |
| Asthma/Bronchitis/Emphysema | | |
| Balance Problems | | |
| Bladder/Bowel Problems | | |
| Blood Clot/DVT/Emboli | | |
| Bone Disease (specify) | | |
| Breathing Problems | | |
| Bruising/Bleeding easily | | |
| Cancer (specify) | | |
| Chest Pain/Discomfort | | |
| Circulation Problems | | |
| Depression | | |
| Diabetes | | |
| Dizziness | | |
| Double Vision | | |
| Ear Pressure/Ringing in the Ears | | |
| Fainting Spells | | |
| Falls/Fractures | | |
| Fatigue | | |
| Fibromyalgia | | |
| Gout | | |
| Headaches/Migraines | | |
| Heart Attack/Disease | | |

| | YES | NO |
|---|---|---|
| Hepatitis | | |
| Hernia | | |
| High Blood Pressure | | |
| High Cholesterol | | |
| HIV/AIDS | | |
| Joint replacements | | |
| Low Blood Pressure | | |
| Lung Disease | | |
| Metal Implants | | |
| Muscle Weakness | | |
| Multiple Sclerosis | | |
| Osteopenia/Osteoporosis | | |
| Polio | | |
| Sensitivity to Cold/Hot | | |
| Shortness of Breath | | |
| Skin Changes | | |
| Sleep Disturbance | | |
| Stroke | | |
| Swelling | | |
| Thyroid (specify) | | |
| Tremors | | |
| Tuberculosis (specify) | | |
| Vascular Disease (specify) | | |
| Weight Gain/Loss | | |
| **Other (specify):** | | |

If you answered "yes" to any of the above conditions, please explain. Also give type of treatment received and approximate date(s) of onset of condition(s) and treatment(s).

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Names and Dosage of Daily Medications (including Over-the-Counter Medications and Supplements)**

______________________________

**Hospitalization/Surgical History (Reason and Approximate Dates)**

______________________________

Do you have any allergies? If yes, list allergies: ______________________________

______________________________

______________________________

Have you had MRI, Ultrasounds, Scans, X-ray or any other diagnostic tests within the last year? If yes, please specify type of test(s), approximate dates and findings.

______________________________

______________________________

______________________________

Please state any other general health concern(s) or specific condition(s) you may have and you think we should know.

I, ______________________________, hereby state that the information contained in this medical history form is complete and correct to the best of my knowledge.

______________________________
Signature of Patient or Legal Guardian

______________________________
Date