physical therapy DIRECT

Patient Past & Present Medical History

Patient Name: _____

Do you currently or have you ever had any of the following? (Type **P** for Past and **C** for Current)

_____Allergies	_____Emboli	_____Osteoporosis
_____Anemia	_____Emphysema	_____Pins or metal implants
_____Angina	_____Emotional Problems	_____Radiation
_____Arthritis	_____Energy Loss	_____Severe Headaches
_____Asthma	_____Epilepsy	_____Seizures
_____Bladder problems	_____Frequent fainting	_____Shortness of breath
_____Blood Clot	_____Goiter	_____Sleep Apnea
_____Bowel Problems	_____Gout	_____Sleeping Problems
_____Bronchitis	_____Hearing difficulty	_____Stroke
_____Cancer	_____Heart attack	_____Swollen Joints
_____Chemotherapy	_____Heart disease	_____Thyroid trouble
_____Chest Pain	_____Heart surgery	_____Vision difficulties
_____Diabetes	_____Joint Replacement	_____Weakness
_____Dizziness	_____Numbness/Tingling	_____Weight Loss

Do you have a pacemaker? YES NO
Do you smoke? YES NO
Are you pregnant? YES NO

Are you currently taking any prescription or non-prescription medication? YES NO
If yes, please list the name and dosage/frequency of medication:
_____
_____

Do you have an attorney for **this** injury? YES NO
Have you had surgery for **this** injury? YES NO
List any other information that would assist us in your care:
_____
_____

Patient Signature:_____ Date: _____