

MEDICAL HISTORY

NAME _____ DATE _____

GENERAL HEALTH

Have you been treated for, or had complaints of:

	YES	NO		YES	NO
High Blood Pressure...	___	___	Diabetes.....	___	___
Seizures.....	___	___	Hypoglycemia.....	___	___
Heart Problems.....	___	___	Chest Pain or Angina..	___	___
Cancer.....	___	___	Stroke.....	___	___
Allergies.....	___	___	Chronic Bronchitis....	___	___
Dizziness.....	___	___	Emphysema.....	___	___
Abdominal Pain.....	___	___	Migraine Headaches...	___	___
Past Fractures.....	___	___	Arthritis / Gout.....	___	___
Joint Pain.....	___	___	Shortness of Breath...	___	___
Night Pain.....	___	___	Hepatitis.....	___	___
Recent Infection.....	___	___	Tuberculosis.....	___	___
Recent Weight Loss...	___	___	Low Back Pain.....	___	___

List any surgeries you have had:

List medications you are taking, if any (include over the counter brands):

Have you ever had physical therapy before? ___ YES ___ NO

What do you want to achieve with the present treatment program?

Is there anything you can think of that your therapist should be aware of that could affect your performance and participation in the program?

Signature: _____