CARE PHYSICAL THERAPY - PAST MEDICAL HISTORY

Name_____ Occupation_____ Age_____

ARE YOU LATEX SENSITIVE? YES NO
DO YOU HAVE ANY OTHER ALLERGIES? (list)_____

FOR WOMEN: ARE YOUR CURRENLY PREGNANT OR DO YOU THINK YOU MIGHT BE PREGNANT? YES NO

PLEASE CHECK IF YOU ARE UNDER THE CARE OF ANY OF THE FOLLOWING:

_____ Medical Doctor	_____ Psychiatrist/Psychologist	Other_____
_____ Osteopath	_____ Physical Therapist	_____
_____ Dentist	_____ Chiropracter	

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

Yes	No	Cancer	Yes	No	Chemical Dependency
Yes	No	Heart Problems	Yes	No	Hepatitis
Yes	No	High Blood Pressure	Yes	No	Tuberculosis
Yes	No	Circulation Problems	Yes	No	Stroke
Yes	No	Asthma	Yes	No	Kidney Disease
Yes	No	Emphysema/Bronchitis	Yes	No	Anemia
Yes	No	Diabetes	Yes	No	Epilepsy/Other Seizures
Yes	No	Thyroid Problems	Yes	No	Pacemaker
Yes	No	Multiple Sclerosis	Yes	No	Headaches
Yes	No	Rheumatoid Arthritis	Yes	No	Dizziness
Yes	No	Other Arthritic Conditions	Yes	No	Depression/Anxiety

PLEASE LIST ANY SURGERYS AND/OR HOSPITALIZATIONS WITH DATES AND REASONS
_____
_____
_____

PLEASE LIST ANY SIGNIFICANT INJURIES FOR WHICH YOU HAVE BEEN TREATED (FRACUTRES, SPRAINS, DISLOCATIONS ETC.) WITH APPROXIMATE DATE OF INJURY
_____

PLEASE LIST ANY **OVER THE COUNTER MEDICATIONS** YOU HAVE TAKEN **THIS WEEK**
1._____ 2._____ 3._____

PLEASE LIST ANY **PERSCRIPTION MEDICATIONS** YOU ARE CURRENLY TAKING
1._____ 2._____ 3._____
4._____ 5._____ 6._____

DO YOU USE ANY ARTIFICIALLY SWEETENED PRODUCTS?	NO	YES, _____ per day
DO YOU DRINK CAFFEINATED BEVERAGES?	NO	YES, _____ per day
DO YOU SMOKE CIGARETTES?	NO	YES, _____ packs per day
DO YOU DRINK ANY ALCOHOLIC BEVERAGES?	NO	YES, _____ days per week _____ drinks per sitting

HAVE YOU RECENTLY NOTICED:

Weight loss/gain	YES	NO	Fatigue	YES	NO
Weakness	YES	NO	Nausea/Vomiting	YES	NO
Fever/chills/sweats	YES	NO	Numbness/Tingling	YES	NO

WHAT GOALS DO YOU WISH TO ACHIEVE WITH PHYSICAL THERAPY? _____
_____

PATIENT SIGNATURE _____ DATE _____
THERAPIST SIGNATURE_____ DATE _____