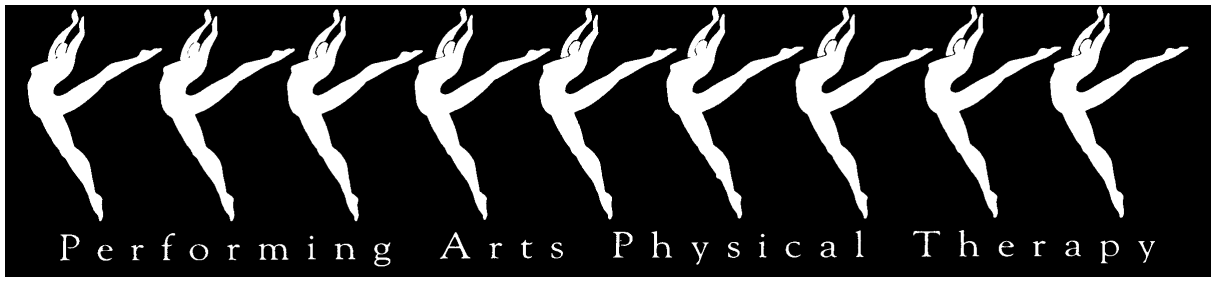

PATIENT PERSONAL AND MEDICAL HISTORY

NAME: _____ _____ _____
FIRST MIDDLE INITIAL LAST

PERMANENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE # (HOME): _____ (WORK): _____

(CELL): _____ EMAIL: _____

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____

AGE: _____ SEX: _____ WEIGHT: _____ HEIGHT: _____

PROFESSIONAL HISTORY:

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S CONTACT PERSON: _____

EMPLOYER'S PHONE: _____ FAX: _____

EMERGENCY CONTACT INFORMATION:

NAME / RELATIONSHIP: _____ TEL _____

INJURY HISTORY:

Date of injury/onset: _____ Referring physician: _____

Diagnosis: _____

Are you currently under a prescription for therapy elsewhere for this injury? _____

MEDICAL HISTORY

Do you smoke? _____ Amount?: _____ Do you drink Alcohol?: _____ Amount?: _____

Eating habits (vegetarian, etc.): _____

PERVIOUS INJURY HISTORY:

Date of injury/onset: _____ What was the injury?: _____

Did the injury resolve?: _____

Are you doing any maintenance exercises for this past injury? _____ If so how often? _____

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

	Yes	No		Yes	No
Diabetes	☐	☐	Osteoporosis	☐	☐
Stroke/ CVA	☐	☐	Asthma/Breathing Difficulties	☐	☐
High Blood Pressure	☐	☐	Allergies	☐	☐
Chest Pain/ Angina	☐	☐	Skin Abnormalities	☐	☐
Heart Disease	☐	☐	Headaches	☐	☐
Pacemaker	☐	☐	Seizures/Neurological Disorder	☐	☐
Cancer	☐	☐	Dizziness/ Fainting	☐	☐
Night Pain	☐	☐	Nausea/ Vomiting	☐	☐
Are you currently pregnant?	☐	☐	Ringing in your ears	☐	☐
Metal Implants	☐	☐	Osteoarthritis	☐	☐
Poor tolerance to Heat/Cold	☐	☐	Rheumatoid Arthritis	☐	☐
Menstrual Irregularities	☐	☐	Motor Vehicle Accident(s)	☐	☐
Bowel/ Bladder Abnormalities	☐	☐	Surgeries	☐	☐
Sexual Dysfunction	☐	☐	Recent Fractures	☐	☐
Kidney Problems	☐	☐	Joint Sprains	☐	☐
Hernia	☐	☐	Other	☐	☐

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

_____

_____

_____

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

_____

_____

_____

Are you presently taking Medication? If yes, please list what medications and for what condition: _____

_____

_____

If you are using Medicare insurance for Physical Therapy, are you currently receiving home care services of any kind? (Ex. Home Health Aid, Wound Care, etc) _____

_____

_____ _____

Signature Date

4/23/2025

Submit