

## Medical History Form

Name; \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you have any history of or are currently being treated for: Yes or No

High Blood pressure \_\_\_\_\_ Heart conditions \_\_\_\_\_

Stroke \_\_\_\_\_ Diabetes \_\_\_\_\_

Seizures \_\_\_\_\_ Cancer \_\_\_\_\_

Allergies \_\_\_\_\_ Pacemaker \_\_\_\_\_

What condition are you seeking treatment for? \_\_\_\_\_

\_\_\_\_\_

Have you had other treatments for this condition? \_\_\_\_\_

Have you ever had Physical Therapy before? \_\_\_\_\_

Are you or might you be pregnant? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

What is your pain level? (scale 1-10) \_\_\_\_\_

What are your goals for care of this condition? \_\_\_\_\_

\_\_\_\_\_

Referring Physician \_\_\_\_\_

Name of orthopedic or other specialist physician \_\_\_\_\_

\_\_\_\_\_

Patient signature and date \_\_\_\_\_

