



**MEDICAL HISTORY**

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Patient's Name \_\_\_\_\_ Date: \_\_\_\_\_

1. Problem with what part of the body? \_\_\_\_\_
2. Surgery date? \_\_\_\_\_

***Return Patients Only:***

3. Any change to your previous medical status? Yes \_\_\_\_\_ No \_\_\_\_\_  
*(If yes, please note change in #4 below.)*
4. Any change to your previous insurance or contact information? Yes \_\_\_\_\_ No \_\_\_\_\_

***(If no changes, stop here; for 'yes' answers, complete the appropriate sections)***

5. Make a check if you have ever been diagnosed with any of the following conditions:

- |                            |                      |                          |
|----------------------------|----------------------|--------------------------|
| _____ High blood pressure  | _____ Diabetes       | _____ Cancer             |
| _____ Arthritis            | _____ Stroke         | _____ Infectious disease |
| _____ Circulation problems | _____ Chest pain     | _____ Fainting spells    |
| _____ Breathing problems   | _____ Osteoporosis   | _____ Heart problems     |
| _____ Pacemaker            | _____ Metal implants | _____ Dizzy spells       |
| _____ Fractures            |                      | _____ Loss of Balance    |
| _____ Other illness _____  |                      |                          |

\_\_\_\_\_ **NONE OF THE ABOVE**

6. Do you have skin allergies? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Are you presently taking medications? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, for: \_\_\_\_\_ pain \_\_\_\_\_ inflammation \_\_\_\_\_ muscle relaxation  
\_\_\_\_\_ other \_\_\_\_\_
8. Any other problems or injuries you think we should know about, or that might affect your ability to exercise? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain \_\_\_\_\_
9. Female patients: Are you now pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_
10. Have you received physical therapy treatment this calendar year? Yes \_\_\_\_\_ No \_\_\_\_\_

