

PEAK PERFORMANCE PHYSICAL THERAPY

Medical History

Patient Name: _____ Date: _____

Referring Physician: _____ Family Physician: _____

How were you injured? _____

Date of injury/Onset: _____ State injury occurred: _____

Date of Surgery: _____ What body part is injured? _____

Medications

Anti-Inflammatories: _____

Muscle Relaxers: _____

Pain Medication: _____

Other Medications and why:

Medical Conditions

| | YES | NO | | YES | NO |
|----------------------------------|-----|-----|------------------------------|-----|-----|
| High Blood Pressure | ___ | ___ | Hernia | ___ | ___ |
| Diabetes | ___ | ___ | Weakness | ___ | ___ |
| Coronary Heart Disease | ___ | ___ | Arthritis | ___ | ___ |
| Heart Attack or Surgery | ___ | ___ | Osteoporosis | ___ | ___ |
| Shortness of Breath/Chest Pain | ___ | ___ | Pins/Metal Implants | ___ | ___ |
| Pacemaker | ___ | ___ | Joint Replacement | ___ | ___ |
| Cancer or Chemotherapy/Radiation | ___ | ___ | Neck Injury/Surgery | ___ | ___ |
| Respiratory Problems | ___ | ___ | Back Injury/Surgery | ___ | ___ |
| Stroke | ___ | ___ | Hip Injury/Surgery | ___ | ___ |
| Blood Clot | ___ | ___ | Shoulder Injury/ Surgery | ___ | ___ |
| Seizures/Epilepsy | ___ | ___ | Elbow/Hand Injury Surgery | ___ | ___ |
| Infectious Disease | ___ | ___ | Leg Injury/Surgery | ___ | ___ |
| Anemia | ___ | ___ | Knee Injury/Surgery | ___ | ___ |
| Vision or Hearing Problems | ___ | ___ | Ankle/Foot Injury Surgery | ___ | ___ |
| Dizziness or Fainting | ___ | ___ | | | |
| Pregnant | ___ | ___ | | | |
| Smoke | ___ | ___ | | | |
| Broken Bones – List: | | | | | |

Patient/Guardian Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____