



Patient Medical History

Patient Name: _____ Date: _____

Referring Physician: _____ Family/Primary Care Provider: _____

Age: _____ Height: _____ Weight: _____

Medical Conditions

Do you have any medical condition you currently suffer from or have experienced in the past? * Yes No

List of Medical Conditions

Please indicate any medical conditions you currently suffer from or have experienced in the past

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> DVT | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Closed Head Injury | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psoriatic Arthritis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Frequent UTI | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> GERD | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> COPD | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bowel Incontinence | <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> MRSA | <input type="checkbox"/> Sleeping Disorder |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Urinary Incontinence |

Other Conditions

Do you have a pacemaker Yes No

List any additional conditions not already included

Orthopedic Injuries & Surgeries

	YES	NO	DATE OF SURGERY		YES	NO	DATE OF SURGERY
Ankle injury/surgery				Neck injury/surgery			
Back injury/surgery				Shoulder injury/surgery			
Elbow injury/surgery				Arthritis			
Knee injury/surgery				Weakness			
Hip injury/surgery							

Please list all medications you are currently taking. If you need additional space, please inform front desk.

Medication	Dosage	Frequency	Delivery	Reason

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____