

In the past, have you been treated for the same problem? Yes No

If yes, whom did you see for that condition? MD Physical Therapist Occupational Therapist
Chiropractor Other _____

When and what treatment did you receive? _____

Are you currently working? Yes No N/A

If not, are you off secondary to this injury? _____

Occupation: _____

Please list current medications and dosage, including over the counter medications: _____

And any allergies: _____

Do you have a pacemaker or other implantable electronic device? _____

Do you exercise regularly? _____

For females, any chance you may be pregnant? _____

MEDICAL HISTORY:

If you have ever had a listed condition in the past year, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assist your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Angina or chest discomfort
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	HIV/Aids
<input type="checkbox"/>	<input type="checkbox"/>	Cancer Location: _____ Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco, Packs/day _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or alcohol dependence

Any recent hospitalizations or surgical procedures? _____

Any recent unusual weight gain or loss? _____

Patient Signature: _____ Date: _____

Therapist Signature— above information reviewed with patient.