

**NAME**\_\_     \_\_\_\_\_\_\_ **AGE** \_     \_\_ **DATE**\_\_     \_\_

**For any YES answers, please describe including date of occurrence/diagnosis below.**

**1. GENERAL:**

Diabetes? No  Yes

Metal implants? No  Yes

Recent unexplained weight loss? No  Yes

Night pain? No  Yes

Appetite loss? No  Yes

Night sweats? No  Yes

Current infection? No  Yes

Hot/cold intolerance? No  Yes

Fatigue? No  Yes

Cancer? No  Yes

Fibromyalgia? No  Yes

HIV positive? No  Yes

**2. CARDIOPULMONARY:**

Heart disease? No  Yes

Family history of diabetes or

heart disease? No  Yes

High blood pressure? No  Yes

A respiratory illness? No  Yes

Pacemaker? No  Yes

**3. ALLERGIES:**

Allergies to medication? No  Yes

Other allergies? No  Yes

4. **EYES, EARS, NOSE, THROAT, ORAL:**

Temporomandibular joint pain

(TMJ)? No  Yes

Hearing loss? No  Yes

Glaucoma? No  Yes

Dizziness? No  Yes

**5. SKIN**:

Contagious rash? No  Yes

Fungus? No  Yes

**6. BREASTS (For Women):**

Lumps? No  Yes

Surgery (i.e. tumor removal,

Implants, etc.)? No  Yes

**7. HEMATOLOGIC:**

A blood disease such as hemophilia,

or other bleeding tendencies? No  Yes

Anemia? No  Yes

Leukemia? No  Yes

**8**. **VASCULAR:**

Poor circulation in hands or feet? No  Yes

Thrombophlebitis? No  Yes

Varicose veins? No  Yes

Skin irritations? No  Yes

Tendency to bruise? No  Yes

Phlebitis? No  Yes

**9. RENAL/URINARY:**

Kidney Disease? No  Yes

Incontinence? No  Yes

**10. PSYCHIATRIC:**

Anxiety/Depression? No  Yes

Counseling? No  Yes

**11. CHEMICAL USE:**

Smoking? No  Yes

Alcohol? No  Yes

Non-prescription drug use? No  Yes

**12. NEUROLOGICAL:**

Headaches? No  Yes

Seizures? No  Yes

Numbness? No  Yes

Weakness? No  Yes

Slurred speech? No  Yes

**13. GASTROINTESTINAL:**

Enlarged liver or spleen? No  Yes

Nausea or vomiting? No  Yes

Ulcer? No  Yes

Crohn’s Disease or Irritable Bowel? No  Yes

Hernia? No  Yes

**14. GENITO-REPRODUCTIVE:**

Pregnant now? Yes No Ever? No  Yes

Hormonal imbalance or

replacement therapy? No  Yes

Infections? No  Yes

Surgeries (i.e. prostate,

hysterectomy)? No  Yes

**15. MUSCULOSKELETAL:**

Arthritis? No  Yes

Osteoporosis? No  Yes

Previous fractures? No  Yes

Previous sprains/strains? No  Yes

Previous back or neck injury? No  Yes

Other? No  Yes

**16. EXERCISE/ACTIVITY:**

Do you exercise regularly

(at least 3 times per week)? No  Yes

Doing what? \_     \_\_\_

How much time each day are you willing and able to do

exercises given to you by your physical therapist?

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**17. MEDICATIONS:**

1.      \_\_\_

2.      \_\_\_

3.      \_\_\_

4.      \_\_\_

5.      \_\_\_

Please use the reverse side if more space is needed. I certify this medical history is accurate and complete. A physical signature is required at the time of your visit.

Date:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Parent or Legal Guardian

PT Reviewed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_