**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?

 \_     \_\_\_\_\_\_\_

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_