

# MEDICAL HISTORY FORM

NAME: \_\_\_\_\_  
REFERRING PHYSICIAN: \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_

DATE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_

## MEDICAL HISTORY

Is your current condition related to an injury? Yes\_\_\_ No\_\_\_  
If YES, was the injury related to: Auto\_\_\_ Work\_\_\_ Other\_\_\_ Date of Injury \_\_\_\_\_

Are there any lawsuits pending regarding your condition? Yes\_\_\_ No\_\_\_

Have you received physical/speech therapy in the last year? Yes\_\_\_ No\_\_\_  
*If YES, refer to your insurance policy for limitations.*

Please check any of the following conditions you have or may have had in the past:

- |                                   |                           |               |
|-----------------------------------|---------------------------|---------------|
| ___ Heart Disease                 | ___ Tuberculosis          | ___ Asthma    |
| ___ High Blood Pressure           | ___ Currently Pregnant    | ___ Stroke    |
| ___ Heart Murmur                  | ___ Fatigue/Energy Loss   | ___ C.O.P.D.  |
| ___ Mood Disorders                | ___ Chest Pain/Discomfort | ___ Hepatitis |
| ___ Shortness of Breath           | ___ Ankle Swelling        | ___ Anemia    |
| ___ Kidney Disease                | ___ Epilepsy/Seizures     | ___ Diabetes  |
| ___ Dizzy Spells                  | ___ Allergies             | ___ Hernia    |
| ___ Headaches                     | ___ Cancer: Type _____    |               |
| ___ Loss of Bladder/Bowel Control | ___ Other: _____          |               |

## ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

- |                           |                                          |
|---------------------------|------------------------------------------|
| ___ Osteoporosis          | ___ Scoliosis                            |
| ___ Broken Bones          | ___ Sprains/Strains                      |
| ___ Arthritis             | ___ Balance/Walking Problems             |
| ___ Fibromyalgia          | ___ Limited Range of Motion              |
| ___ Slipped/Ruptured Disc | ___ Subluxed/Dislocated Joints           |
| ___ Weakness              | ___ Painful Grinding/Cracking in a Joint |
| ___ Compression Fractures |                                          |

Have you had a recent: X-Ray\_\_\_ MRI\_\_\_ CT Scan\_\_\_  
If so, when? \_\_\_\_\_

Please list hospitalizations or surgeries you have had in the last five years, including dates:

\_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking:

\_\_\_\_\_

Are you allergic to any medications: Yes\_\_\_ No\_\_\_ If yes, please list: \_\_\_\_\_

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

Date: \_\_\_\_\_  
Date: \_\_\_\_\_