Patient History Form

Name ________________________ Sex __________ Date of Birth ______________
Please complete all required information. Use reverse side, if needed, for additional space.

1. Have you ever had?

High Blood Pressure	Yes	No	Breathing Problems	Yes	No
Heart Trouble	Yes	No	Fracture	Yes	No
Circulation Problems	Yes	No	Stroke	Yes	No
Seizures	Yes	No	Arthritis	Yes	No
Dizzy Spells	Yes	No			
Diabetes	Yes	No			

2. Have you ever had Surgery? No Yes If Yes, give Date(s), Operation(s), and Outcome(s) ____

3. Do you have any metal anywhere in your body (other than your teeth)? No Yes

4. Do you have a Cardiac (heart) Pacemaker? No Yes

5. (For Women Only) Are you now pregnant? No Yes

6. List any medical tests done for condition for which you were referred to us:
____

7. List any allergies you have ____

8. List any Medication you are now taking ______________________________________

9. Have you ever had Physical Therapy treatments before? No Yes

If Yes, indicate Where, When, and for What problem______________________________
____

10. Describe briefly the history of your present accident or illness ___________________
____

11. Please list any past or present medical conditions you have ______________________
____

12. Please list prior accidents or work injuries____________________________________
____

13. Work Status Regular Duty Light Duty Off Duty

___________ Date __________________________ Signature (if not patient, indicate relationship)