

NAME: _____ AGE: _____ DATE: _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____

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: _____

Have you received physical 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:

- | | | |
|--|---|--|
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> DIABETIC |
| <input type="checkbox"/> PHLEBITIS | <input type="checkbox"/> STROKE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> MURMURS | <input type="checkbox"/> C.O.P.D. | <input type="checkbox"/> CURRENTLY PREGNANT |
| <input type="checkbox"/> HERNIA | <input type="checkbox"/> ANKLE SWELLING | <input type="checkbox"/> FATIGUE/ENERGYLOSS |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> CANCER: TYPE _____ |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> EPILEPSY/SEIZURE | <input type="checkbox"/> CHEST PAIN/DISCOMFORT |
| <input type="checkbox"/> LOSS OF BLADDER/BOWEL CONTROL | <input type="checkbox"/> ALLERGIES | |

ORTHOPAEDIC LIMITATIONS

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

- | | | |
|--|---|---|
| <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> WEAKNESS | <input type="checkbox"/> LIMITED RANGE OF MOTION |
| <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> COMPRESSION FRACTION | <input type="checkbox"/> SUBLUXED/DISLOCATED JOINTS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> PAINFUL GRINDING |
| <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> SPRAINS/STRAINS | |
| <input type="checkbox"/> SLIPPED/RUPTURED DISC | <input type="checkbox"/> BALANCE/WALKING PROBLEMS | |
| | | <input type="checkbox"/> CRACKING IN A JOINT |

Have you had a recent: X-RAY _____ MRI _____ CT SCAN _____
WHEN: _____

Please list hospitalizations or surgeries you have had, including dates:

Medications currently taking:

Are you allergic to any medications? Yes _____ No _____

If YES, please list:

