Rehabilitation Physical Therapy
Relieving pain. Restoring lives. One patient at a time.

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PATIENT MEDICAL HISTORY
PATIENT INFORMATION

Name _____ Age _____ Date_____

Address_____

City _____ State _____ Zip _____

PLEASE ANSWER THE FOLLOWING QUESTION:

Are you presently taking any medication? ❑ YES ❑ NO
If YES, please list your Medications and for what condition _____

_____

Have you had any x-rays MRIs or CAT scans or other diagnostic tests for your recent disorder? ❑ YES ❑ NO
If YES, please explain _____

_____

Do you have limitations to exercise? ❑ YES ❑ NO
If YES, please explain _____

_____

Do you have now, or have you ever had any of the following: (please check yes or no)

Diabetes	❑ YES	❑ NO	Allergy To Cold	❑ YES	❑ NO
High Blood Pressure	❑ YES	❑ NO	Other Allergies	❑ YES	❑ NO
Pacemaker	❑ YES	❑ NO	Previous Surgery	❑ YES	❑ NO
Chronic Headaches	❑ YES	❑ NO	Seizures	❑ YES	❑ NO
Kidney Problems	❑ YES	❑ NO	Metal Implants	❑ YES	❑ NO
Nervous Disorders	❑ YES	❑ NO	Dizziness	❑ YES	❑ NO
Hernia	❑ YES	❑ NO	Cancer	❑ YES	❑ NO
Allergy To Heat	❑ YES	❑ NO	Pregnant	❑ YES	❑ NO
Bone Disease	❑ YES	❑ NO	Osteoporosis	❑ YES	❑ NO
Fractures	❑ YES	❑ NO	Bowel Problems	❑ YES	❑ NO
Bladder Problems	❑ YES	❑ NO	Recent Weight Loss	❑ YES	❑ NO