PATIENT HISTORY

NAME: ______________________________ DATE OF NEXT MD APPOINTMENT: ______________

Describe briefly the history of your present ACCIDENT, INJURY, ILLNESS OR CONDITION:
Onset Date: __________ Description: ____
____
____

Please list any special concerns, questions or expectations:____
____

Have you fallen in the past year? _______ If so, how many times? ________ If so, did you sustain an injury?____

Have you had any physical therapy during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? ______ If yes, please indicate where and when:
____

List **ALL** medications you are currently taking:____
____
____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____________________
____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.?
Describe ____

Please list **ALL** surgeries you have had; please give procedures and dates, if possible: __________________
____
____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Tobacco use	Yes	No
Diabetes	Yes	No			

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SIGNATURE: ___________________________________ DATE:___________________________

Rev. 6/26/07