

PATIENT HISTORY

NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Please complete all requested information

1. Have you ever had? (If Yes, please explain)

High Blood Pressure	No	Yes	_____
Heart or Circulation Disorders	No	Yes	_____
Seizures	No	Yes	_____
Dizzy Spells	No	Yes	_____
Diabetes	No	Yes	_____
Cancer	No	Yes	_____
Arthritis/ Osteoarthritis	No	Yes	_____
Osteoporosis	No	Yes	_____
Immune deficiency Disease	No	Yes	_____
Other	No	Yes	_____

2. Please list surgeries you have had; please give procedures and dates; if possible:

\_\_\_\_\_

3. Please list recent diagnostic studies (Cat-Scan, MRI, X-rays): \_\_\_\_\_

\_\_\_\_\_

4. Do you have any metal anywhere in your body; pins/ plates post fracture, or pacemaker (other than teeth)? No Yes, Describe: \_\_\_\_\_

5. (For women only) Are you now pregnant? No Yes. Date of last menstrual cycle: \_\_\_\_\_

6. Do you have any abnormal trouble with vision? No Yes / Hearing? No Yes

7. List any allergies you may have: \_\_\_\_\_

8. Have you ever taken steroids or anti-coagulants for an extended period of time? No Yes

9. Have you had an unusual weight gain or loss lately? No Yes

10. List medications you are now taking: \_\_\_\_\_

\_\_\_\_\_

11. Have you ever had physical therapy treatments before? No Yes  
If yes, please indicate where, when, and for what problem: \_\_\_\_\_

\_\_\_\_\_

12. Describe briefly the history of your present **ACCIDENT, INJURY OR ILLNESS:**  
Onset: \_\_\_\_\_ Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. Date of next Doctor appointment: \_\_\_\_\_