MEDICAL HISTORY FORM PERFORMANCE PHYSICAL THERAPY

Please check if you have, or have had, any of the conditions listed below:

| | | | | | |
|---|---|---|---|---|---|
| Allergies | Yes ☐ No ☐ | Depression | Yes ☐ No ☐ | Multiple sclerosis | Yes ☐ No ☐ |
| Anemia | Yes ☐ No ☐ | Diabetes | Yes ☐ No ☐ | Osteoporosis | Yes ☐ No ☐ |
| Anxiety | Yes ☐ No ☐ | Dizzy spells | Yes ☐ No ☐ | Parkinson's | Yes ☐ No ☐ |
| Arthritis | Yes ☐ No ☐ | Emphysema/Bronchitis | Yes ☐ No ☐ | Rheumatoid arthritis | Yes ☐ No ☐ |
| Asthma | Yes ☐ No ☐ | Fractures | Yes ☐ No ☐ | Seizures | Yes ☐ No ☐ |
| Cancer | Yes ☐ No ☐ | Gallbladder problems | Yes ☐ No ☐ | Speech problems | Yes ☐ No ☐ |
| Cardiac Conditions | Yes ☐ No ☐ | Hepatitis | Yes ☐ No ☐ | Strokes | Yes ☐ No ☐ |
| Cardiac Pacemaker | Yes ☐ No ☐ | High blood pressure | Yes ☐ No ☐ | Thyroid disease | Yes ☐ No ☐ |
| Chemical Dependency | Yes ☐ No ☐ | Incontinence | Yes ☐ No ☐ | Tuberculosis | Yes ☐ No ☐ |
| Circulation Problems | Yes ☐ No ☐ | Kidney problems | Yes ☐ No ☐ | Vision problems | Yes ☐ No ☐ |
| Currently Pregnant | Yes ☐ No ☐ | Metal Implants | Yes ☐ No ☐ | | |

Describe any other conditions or precautions: _____
_____

## Fall History:

Have you sought medical attention as a result of a fall in the past year? Yes ☐ No ☐

Have you had two or more falls in the past year? Yes ☐ No ☐

## Surgical History:

List past surgeries, and approximate dates of surgeries:

_____
_____
_____

## Current Medications (including prescriptions, over-the-counter meds, Vitamins, Supplements):

| *Medication name* | *Dosage* | *Frequency* | *How do you take it?* |
|---|---|---|---|
| | | | By mouth ☐ Injection☐ Other : _____ |
| | | | By mouth ☐ Injection☐ Other : _____ |
| | | | By mouth ☐ Injection☐ Other : _____ |
| | | | By mouth ☐ Injection☐ Other : _____ |
| | | | By mouth ☐ Injection☐ Other : _____ |

*Please attach a sheet if more room is needed.*

Do you have a follow up appointment scheduled with the Doctor who referred you to our clinic? Yes ☐ No ☐
If so, when? _____

Completed by: _____Signature_____ Date_____
(Printed name) (Patient's signature)

| | | | | | |
|---|---|---|---|---|---|
| Initials _____Date_____ | Initials _____Date_____ | Initials _____Date_____ | Initials _____Date_____ | Initials _____Date_____ | Initials _____Date_____ |