



Medical History Form

Patient Name: _____ Date: _____

Referring Physician: _____ Primary Care Physician: _____

Hospitalizations (Recent/Major Injuries/Surgeries): _____

Are you allergic to LATEX: YES NO Are you allergic to Dexamethasone: YES NO

Have you, or will you, be receiving any of the following tests as a result of your current injury:

X-Ray EMG CT Scan Doppler Study MRI Other: _____

Results of Test(s): _____

Do you wear Contacts or Glasses: YES NO

Have you fallen in the last year: YES NO If YES, how many times: _____

If YES to falling, did you sustain any injuries: YES NO

Do you currently have any "flu type" symptoms (ie. fever, cough): YES NO

Have you been in contact with anyone who has tested positive or experienced symptoms of COVID: YES NO

Do you currently have any COVID symptoms (ie. loss of taste/smell, cough, fever): YES NO

Do you have any open cuts, lesions or wounds: YES NO If YES, where: _____

Do you use tobacco: YES NO If YES, how much: _____

Do you current have or have a history of any of the following? (Please mark all that apply)

- Grid of checkboxes for various medical conditions: Anemia, Diabetes, High/Low Blood Pressure, Angina, Controlled, Uncontrolled, Arthritis, Depression, Fractures/Broken Bones, Cancer, Dizziness/Fainting, Headaches, Cardiovascular Problems, Kidney Problems, Hepatitis/HIV/AIDS, Holter Monitor, Pacemaker, MRSA, Osteoporosis, Asthma/COPD/Other, Seizures, Thyroid Problems, Blood Thinners, Frequent Swelling, Pregnant or possibility of pregnancy, Frequent Diarrhea/Nausea, Tuberculosis, Poor Hearing, Paralysis, Head Injury, Metal Implants

Reason for attending Therapy: _____

What tasks/activities do you find you have most difficulty with: _____

What are your personal goals/outcomes you wish to see from treatment: _____

Was this injury work related: YES NO If yes, Date of injury: _____

Was this injury a result of an accident (auto or 3rd party): YES NO If yes please explain: _____

Work Status: Full Time Part Time Off Work Do you have restrictions: YES NO

Signature of Patient: _____

Reviewed by: _____ Date: _____