HEALTH INFORMATION

HAVE YOU EVER HAD OR BEEN TOLD YOU HAD: (CHECK IF YES)

☐ HEART OR ARTERY DISEASE
☐ DIABETES
☐ MENTAL OR NERVOUS DISORDER
☐ BIRTH DEFECT
☐ HIGH BLOOD PRESSURE
☐ CANCER OR MALIGNANCY
☐ ULCER OR DIGESTIVE DISORDER
☐ GENITO-URINARY PROBLEMS
☐ GOUT
☐ CHEST PAINS
☐ RESPIRATORY DISORDER

1. IS YOUR HEARTBEAT EVER IRREGULAR? ○ YES ○ NO

2. DO YOU WEAR A PACEMAKER? ○ YES ○ NO

3. DO YOU CARRY NITROGLYCERIN TABLETS? ○ YES ○ NO

4. HAVE YOU BEEN TOLD THAT YOU HAVE ANY TYPE OF ARTHRITIS OR RHEUMATISM?
○ YES ○ NO

5. ARE YOU ON MEDICATION PRESCRIBED BY A PHYSICIAN? ○ YES ○ NO
IF YES PLEASE LIST YOUR MEDICATIONS:_____
_____

6. PLEASE LIST ANY OPERATIONS, SERIOUS ILLNESSES, ACCIDENTS, OR ANY BROKEN BONES THAT YOU HAVE HAD FROM BIRTH TO THE PRESENT:
_____

7. YOUR PRESENT WEIGHT:_____ HEIGHT:_____ DO YOU SMOKE?_____

8. HAVE YOU GAINED OR LOST WEIGHT IN THE PAST 12 MONTHS?_____

9. ARE YOU PREGNANT? ○ YES ○ NO

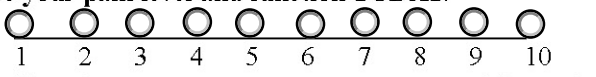
10. WHY ARE YOU IN NEED OF PHYSICAL THERAPY? _____

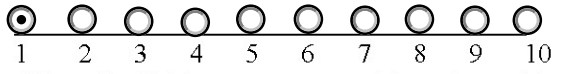
11. WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? _____

In case of emergency whom do we contact? _____
Phone Number: ( ) _____

ADDITIONAL COMMENTS AND/OR INFORMATION YOU WOULD LIKE TO ADD?
_____

Please mark the following diagrams/scales as they describe your pain level and function TODAY.





I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AT THE PRESENT TIME.

SIGNED:_____ DATE:_____

REVIEWED:_____ DATE:_____

Print Form