Medical History

Patient Name:_____ Date:_____

Medical Conditions: □ N/A

□ Allergies □ HIV/Aids □ Bowel Dysfunction □ High Blood Pressure

□ Autoimmune: _____ □ Asthma/COPD □ Bladder Dysfunction

□ Cancer: _____ □ Heart Condition: _____

□ Neurological: _____ □ Headaches □ Hypothyroid

□ Rheumatoid Arthritis □ Malaise/Fatigue □ Women's/Men's Health Issues: _____

□ Hepatitis □ Fibromyalgia □ Osteoporosis □ Dizziness/Fainting

□ Diabetes □ Steroids □ Osteoarthritis □ Nausea/Vomiting

□ Falls(past yr): _____ □ Epilepsy □ Blood thinners

□ Fractures: _____ □ Shortness of Breath □ Pregnancy

□ Mental/Cognitive Disorder: _____ □ Weight Change: _____

□ Other: _____

Previous Surgeries/Implants: □ N/A

	When	**Details**

Previous Accidents/Injuries:

_____
_____
_____
_____

Recent Hospitalizations and/or other **Physical Therapy** (since Jan 1st):

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

Medications/Supplements: □ N/A

	Dose	**Reason**

Social History

Living Situation: □ Alone □ Family/Roommate □ House □ Apartment □ Stairs in/to access home

Smoker: □ N/A □ Current: _____ □ Previous: _____

Alcohol: □ N/A □ Often □ Occasionally □ Previous history

Drugs: □ N/A □ Often □ Occasionally □ Previous history

General Health: □ Excellent □ Good □ Fair □ Poor

Any other information you feel is important for us to know:

_____
_____
_____
_____

Signature of Patient:_____

Therapist:_____