MEDICAL HISTORY

PATIENT NAME: _____DATE:_____

DATE OF NEXT ORTHOPAEDIC DOCTOR'S APPOINTMENT: _____

1. Why are you being referred to physical therapy?
   _____
   _____

2. Have you had physical therapy in the past year? YES / NO

3. Do you have any of the following conditions?

   A) High Blood Pressure YES / NO
   B) Low Blood Pressure YES / NO
   C) Diabetes YES / NO
   D) Heart/Lung Problems YES / NO
   E) Metal Implants YES / NO
   F) Cancer YES / NO
   G) Other orthopaedic conditions YES / NO
   H) Are you pregnant? YES / NO

4. Have you had surgery for this orthopaedic condition? YES / NO
   If yes, date of surgery: _____

5. List all tests that you have had for this condition (i.e. X-rays, MRI, CT scan, EMG, etc.)
   _____

6. List all treatments that you have had for this condition:

   - Chiropractic Care
   - Massage
   - Injection
   - Other: _____

7. List all medications that you are currently taking: _____
   _____

8. What are your goals for physical therapy? _____
   _____

Patient Signature _____ **Date** _____

*Please bring this completed form with you to your initial Physical Therapy appointment.