

Patient Information

Name _____ **Date of Birth:** _____

Home Address: _____ **Phone Number:** _____

_____ **Email Address:** _____

Medical History

Please check if you have had or currently have any of the following:

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic Surgery
- Other: _____

Digestive

- Nervous Stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive Aids
- Other: _____

Circulatory/Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problem
- Asthma
- High blood Pressure
- Low blood pressure
- Lymphedema
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson’s disease
- Spinal cord injury
- Other: _____

Reproductive System

- Pregnancy
- Current Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostrate problems

Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use _____
- Alcohol use _____
- Nicotine use _____
- Caffeine use _____
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious Disease
- Please List _____

Surgeries you have had: _____

Have you received any special medical tests, i.e. MRI scans, EMG, etc. for your current problem?

Family Physician _____ Last Visit Date _____

Orthopedic Doctor _____ Last Visit Date _____

Why were you referred for Physical Therapy? _____

