PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

- Medical History -

Name: _____ **Account #:** _____ **Date:** _____
Date of birth and age:_____

Date last seen by your Physician for this condition?_____
Have you been treated this year by a physical or speech therapist?_____
Have you been treated this year by an acupuncturist or chiropractor?_____
Have you received Home Health treatment or services in the last 30 days? _____
Are you currently receiving other care for this condition? _____
At the present time, would you say that your health is: ____excellent ____very good ____fair____poor?

Please mark the medical conditions that apply:

- ☐ Arthritis
- ☐ Broken Bones/Fracture
- ☐ Blood disorders
- ☐ Circulatory / Vascular Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Cancer-type _____
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes / High Blood Sugar
- ☐ Low Blood Sugar / Hypoglycemia
- ☐ Kidney Problems
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Skin Disorders
- ☐ Head Injury
- ☐ Prostate Conditions
- ☐ Neurological Problems
- ☐ Depression

Other (please describe):_____

Allergies (list):_____

Medications (list):_____
_____
_____

Recent Medical Testing:_____

Surgeries (include date):_____
_____
Do you have metal/hardware in your body as a result of surgery?_____

Have you experienced any of the following symptoms during the last year?

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Dizziness or Blackouts
- ☐ Joint Pain or Swelling
- ☐ Pain at Night
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Bowel Problems
- ☐ Urinary Problems
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Headaches
- ☐ Weight Loss or Gain
- ☐ Coordination Problems
- ☐ Weakness in Arms or Legs