PAST MEDICAL HISTORY FORM

Patient Name: _____ **Date:** _____

Are you presently working? ☐ Yes ☐ No **Date of next physician's visit:** ___/___/___ (if applicable)

Date of injury/surgery/onset: ___/___/___ **Have you ever had PT for these symptoms before?** ☐ Yes ☐ No

Check which apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Injury related to falling
☐ Surgery related ☐ Sports injury ☐ Other: _____

Do you have, or have you had any of the following?

	Yes	*No*		*Yes*	*No*
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain/Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies/Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Allergies to Latex	☐	☐
Heart Attack	☐	☐	Seizures	☐	☐
Heart Palpitations	☐	☐	Metal Implants	☐	☐
Pacemaker	☐	☐	Headaches	☐	☐
Kidney Problems	☐	☐	Dizziness / Fainting	☐	☐
Stroke/CVA	☐	☐	Recent Fracture	☐	☐
Are you Pregnant?	☐	☐	Metal Implants	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Nausea/ Vomiting	☐	☐
Ringing in your ears	☐	☐	Asthma/Breathing Difficulties	☐	☐
Rheumatoid Arthritis	☐	☐	Smoking	☐	☐
Hypoglycemia	☐	☐	Other:_____	☐	☐

Is there any other information regarding your past medical history that we should know about? (comment below)

Are you currently taking Medication? ☐ Yes ☐ No
If yes, please list what medications and for what condition/s below:

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe:

Please indicate/circle where your symptoms are located: