Please list any past hospitalizations: _____

_____

_____

Past Medical History:

- ☐ Asthma
- ☐ Sleeping Problems
- ☐ Allergies
- ☐ Shortness of Breath
- ☐ Emotional/Psychological
- ☐ Anemia
- ☐ Coronary Artery Disease
- ☐ Headaches
- ☐ Infectious Disease
- ☐ Chest Pain
- ☐ Numbness/Tingling
- ☐ Neurological Problems
- ☐ Pacemaker
- ☐ Fainting
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Blurred Vision
- ☐ Metal Implants
- ☐ Heart Attack
- ☐ Ringing in the Ears
- ☐ Cancer
- ☐ Heart Surgery
- ☐ Weakness
- ☐ Smoking
- ☐ Stroke or TIA
- ☐ Weight Loss
- ☐ Arthritis/swollen joints
- ☐ Blood clot or emboli
- ☐ Night sweats
- ☐ Check if Pregnant
- ☐ Epilepsy or Seizures
- ☐ Hernia
- ☐ Osteoporosis
- ☐ Thyroid trouble or Goiter
- ☐ Varicose Veins
- ☐ Incontinence

Please list three goals you would like to achieve while in physical therapy:

1. _____

2. _____

3. _____

Will you need us to send any information to your attorney? ☐ Yes ☐ No

If yes, please provide name, address and contact phone number: _____

_____

_____

√ **Patient/Guardian Signature:** _____ **Date:** _____

EMERGENCY CONTACT NAME _____ **RELATIONSHIP** _____

NUMBER _____

FOR OFFICE USE ONLY:
I Have read the medical history of: _____