Patient Health Information Name: ________________________________

Please put a check in the box next to any medical conditions you may have, or have had in the past.

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Lupus/SLE
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Osteoporosis
- ☐ Headaches/Migraines
- ☐ Leg Cramps
- ☐ Jaw pain/TMJ
- ☐ Bulging Disks
- ☐ Other: ____________

Circulation/Respiration
- ☐ Heart Condition
- ☐ Heart Attack
- ☐ Heart Arrhythmias
- ☐ Pace Maker
- ☐ High Cholesterol
- ☐ Blood Clots/Phlebitis
- ☐ Anemia
- ☐ Other: _____________

Digestion
- ☐ Diabetes
- ☐ Kidney Problem
- ☐ Irritable bowel
- ☐ Bladder problem
- ☐ Liver problem
- ☐ Hernia
- ☐ Other: ________

Nervous System
- ☐ Stroke/TIA
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Epilepsy/Seizures
- ☐ Concussion/Brain injury
- ☐ Numbness or tingling
- ☐ Vertigo
- ☐ Other: _____________

Infectious Diseases
- ☐ TB
- ☐ Hepatitis
- ☐ Polio
- ☐ Other: ________

Skin
- ☐ Skin allergies/rashes
- ☐ Eczema/psoriasis
- ☐ Infectious skin diseases
- ☐ Shingles
- ☐ Latex Allergy
- ☐ Other ______________

Please list any prior accidents, broken bones, or surgeries with approximate dates:________________________
____

1. Have you fallen in the last year? ____

2. Have you had surgery for this injury? Yes___ No___ Surgery Date(s): _____________________________

3. When did pain begin? (Date of Injury) ____

4. Have you had any Medical or Rehabilitative services for this injury/episode? Yes ___ No ___

5. Are you currently taking any prescription or non-prescription medications? If so please list them: __________
____

6. Do you Smoke? Yes ___ No ___ 6. Are you pregnant? Yes ___ No ___

7. Based upon your awareness, what are your expectations/goals while in Therapy? _______________________
____
____

8. Height__________________________________ Weight____

Patient/Guardian Signature: ____ Date: ________________________