

In Motion Physical Therapy

Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you.

Last Name: _____ First: _____ D.O.B: _____ Age: _____
Diagnosis: _____
Physician: _____

Are you currently seeing any of the following? Please check all that apply.

- Medical Doctor (MD) Physical Therapist/Occupational Therapist Chiropractor
 Osteopath Psychiatrist/Psychologist Oral Surgeon

If you have seen any of the above during the past three months, please describe for what reason: _____

PERSONAL MEDICAL HISTORY:

Have you ever been diagnosed as having any of the following conditions? Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Cancer: Please, describe what kind: _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> unusual reaction to heat/cold |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Chemical Dependency (i.e., alcoholism) |
| <input type="checkbox"/> Heart Condition/Angina | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other Arthritis conditions |
| <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Pregnant or planning to become pregnant |
| <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Visual/Hearing difficulties | |

Please list any surgeries or other conditions for which you have been hospitalized for, including the approximate date and reason for the surgery or hospitalization in the past 10 years:

<u>Date</u>	<u>Surgery/Hospitalization</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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