



Physical Therapy & Sports Medicine

NAME: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____

What is your main concern or goal that you would like to accomplish from physical therapy? _____

Do you work outside the home _____ If yes please answer the following: Job title _____
Job Description _____ Is your visit job related _____
When was your last day of work _____

MEDICAL HISTORY—Please circle any of the following that you have or have had

- | | |
|--------------------------------|-------------------------|
| Allergies | High Blood Pressure |
| Anemia | Kidney Disease |
| Angina | Kidney Stones |
| Asthma | Liver disease |
| Chest pain | Lung disease |
| Cancer | Migraine headaches |
| Liver cirrhosis | Osteoarthritis |
| Chronic bronchitis | Polio |
| Diabetes | Rheumatic/Scarlet fever |
| Digestion problems | Rheumatoid arthritis |
| Emphysema | Shortness of Breath |
| Gout | Stroke |
| Heart disease | Ulcers |
| Hepatitis or jaundice | Vision problems |
| Recent unexplained weight gain | Weight loss |
| Unexplained changes on skin | Unusual lumps on body |
| Recent illness | Difficulty swallowing |
| Frequent dizzy spells | Blood in urine or stool |

Have you ever had surgery _____

Do you use an assistive device such as a hearing aid or walker _____
Describe any medical care received for your current condition _____

List any medications currently taken _____

Thanks for Choosing Us!