Medical History Form

Print Name: ____

Please list or provide a copy of your medications: ____
____
____

Please list of provide any medical procedures that may impact your care: __________________________
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Any Medical Implants: Y N   Any History of Cancer: Y N   Women: Are you pregnant? Y N

If you've answered yes, please give details of Medical Implant, location/type of cancer, or months pregnant: ____
____
____

Please circle if you now have or have previously had a history of:

Alzheimer's/Dementia	Huntington's Disease
Cardiovascular disease	Connective Tissue Disorders
Cauda Equina Syndrome/Spina bifida	Immunosuppression
Cerebral Vascular Accident/Stroke	Lupus/Lyme Disease
Recent/Current Infection	Muscular Dystrophy
Diabetes Type 1	Arthritis: Type______________
Diabetes Type 2	Parkinson's Disease
Fibromyalgia	Traumatic Brain Injury
Fracture or suspected Fracture	Mental Health Issues
High Blood Pressure/Hypertension	Other: ____________________________
History of Blood DVT/Blood Clots	____________________________

What are some of the things that you like to do/want to get back to doing? ________________________
____

What is your goal for physical therapy? ____
____

Signature:____ Date:______________________