

Physical Therapy & Sports Medicine Institute, LLC
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out the medical questions as completely as possible. This is very important information. It is important for your Physical therapist to know that you have carefully reviewed every area of this form. This information will be entered into the computer system.

Patient Name: _____ M F Date of Birth: _____ Appt. Date: _____

Mobile Phone: _____ Height _____ Weight _____

Name of Primary Care (Family) Physician _____ Phone _____

Physical Therapy Requested By: _____ Phone _____

Where did you get our name from: _____ Phone _____

Emergency Contact _____ Phone _____

Are you taking **ANY** kind of medication now? No Yes If yes, please list: _____

Past Health History

Cancer No Yes Type _____
Heart Attack No Yes
Heart Disease No Yes
Hypertension No Yes
Asthma No Yes
Bursitis No Yes
Gastritis No Yes

Ulcer No Yes
Arthritis No Yes Type _____
Stroke No Yes
Anxiety No Yes
Fractures No Yes
Diabetes No Yes Type _____
Major Infection No Yes

Are you pregnant or suspect that you may be pregnant? No Yes

Have you ever had surgery before? No Yes

If yes, please list all surgeries :

Today's Problem: _____

Date of onset: _____ Recurrences if any: _____

How did it happen: _____

Where did it happen: _____
Prior treatment for this problem, if any : _____

I, the undersigned, do hereby give my consent to the staff of Physical Therapy & Sports Medicine Institute to provide Physical Therapy care and treatment.

Patient/Guardian Signature _____ Date _____

Patient Name: _____ **Witness** _____