DonnéFIT Physical Therapy

MEDICAL HISTORY FORM

NAME: _____ DATE: _____
REFERRING PHYSICIAN: _____ DATE OF BIRTH: _____
FAMILY PHYSICIAN: _____

MEDICAL HISTORY

Is your current condition related to an injury? **Yes___** **No___**
If YES, was the injury related to: **Auto___** **Work___** **Other___** **Date of Injury** _____

Are there any lawsuits pending regarding your condition? **Yes___** **No___**

Have you received physical/speech therapy in the last year? **Yes___** **No___**
If YES, refer to your insurance policy for limitations.

Please check any of the following conditions you have or may have had in the past:

_____ Heart Disease
_____ High Blood Pressure
_____ Heart Murmur
_____ Mood Disorders
_____ Shortness of Breath
_____ Kidney Disease
_____ Dizzy Spells
_____ Headaches
_____ Loss of Bladder/Bowel Control
_____ Tuberculosis
_____ Currently Pregnant
_____ Fatique/Energy Loss
_____ Chest Pain/Discomfort
_____ Ankle Swelling
_____ Epilepsy/Seizures
_____ Allergies
_____ Cancer: Type_____
_____ Other: _____
_____ Asthma
_____ Stroke
_____ C.O.P.D.
_____ Hepatitis
_____ Anemia
_____ Diabetes
_____ Hernia

ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

_____ Osteoporosis
_____ Broken Bones
_____ Arthritis
_____ Fibromyalgia
_____ Slipped/Ruptured Disc
_____ Weakness
_____ Compression Fractures
_____ Scoliosis
_____ Sprains/Strains
_____ Balance/Walking Problems
_____ Limited Range of Motion
_____ Subluxed/Dislocated Joints
_____ Painful Grinding/Cracking in a Joint

Have you had a recent: X-Ray___ MRI___ CT Scan___
If so, when? _____ _____ _____

Please list hospitalizations or surgeries , including dates:

_____

_____

Please list any medications you are currently taking:

_____

Are you allergic to any medications: Yes___ No___ If yes, please list: _____

Patient Signature: _____ Date: _____