Advantage Physical Therapy

Medical History

Patient Name: ____ Date of next physician's visit? _________

Date of Injury:___/___/_____ Have you had a related surgery? □ Yes □ No

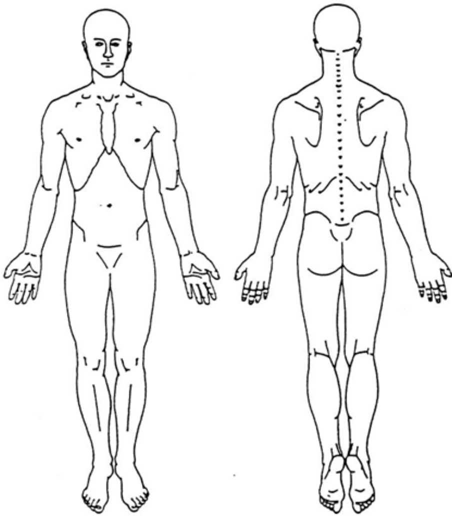
Have you ever had these symptoms before? □ Yes □ No Date of surgery:___/___/______

Age: _____ Height: ________ Weight: ________ Blood Pressure (if known): _____________

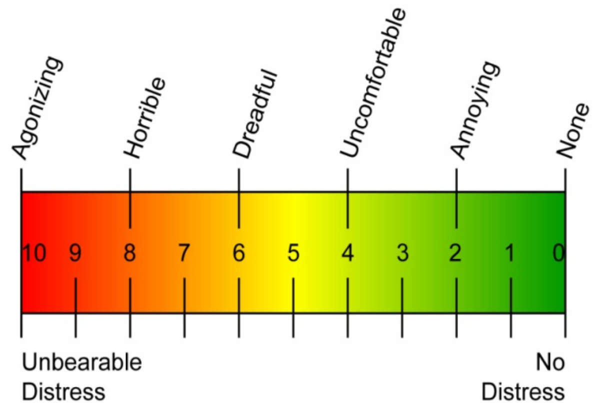
Do you have any of the following:

	Yes	No		Yes	No
Diabetes	□	□	Seizures	□	□
High Blood Pressure	□	□	Allergies	□	□
Heart Disease	□	□	Arthritis	□	□
Heart Attack	□	□	Osteoporosis	□	□
Pace Maker	□	□	Infectious Disease	□	□
Pregnant	□	□	Depression	□	□
Cancer	□	□	Smoking	□	□
Asthma	□	□	Other: _____________________		

Indicate areas of pain:



Circle number that corresponds with worst and least pain intensity:



Are you presently taking medication? □ Yes □ No

If yes, please list what medications and for what condition: ______________________________

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Is there any other information regarding your past medical history that we should know about? _______

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Signature: ____ Date: ________________