integration PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Name: _____ Age:_____ Date: _____

Do you currently have pain? Yes / No If so where? _____
_____
Have you had any recent FALLS? Yes/No If so, date of last fall _____
Do you have any of the following symptoms? (circle) TMJ pain / jaw clicking / breathing difficulties / headache / dizziness / incontinence / bowel/bladder changes / visual changes

Have you had any treatment for this condition? _____
Have you ever had Physical Therapy before? If yes when and for what _____

Have you ever had a concussion? Yes / No Loss of consciousness? Yes / No

Past surgery? _____

Do you have any of the following conditions?

Allergies	Yes / No	Describe: _____
Asthma/exercise induced	Yes / No	Describe: _____
Metal Implants	Yes / No	Describe: _____
Heart disease	Yes / No	Describe: _____
High blood pressure	Yes / No	Describe: _____
Cancer	Yes / No	Describe: _____
Diabetes	Yes / No	Describe: _____
Eye trauma	Yes / No	Describe: _____
Whiplash / MVA	Yes / No	Describe: _____
Pregnant	Yes / No	Describe: _____
Osteoporosis	Yes / No	Describe:_____
Do you smoke	Yes / No	Describe:_____

Do you have any other medical conditions that we need to be aware of that may affect your physical therapy? _____

Please list any medications you are taking: _____
_____
Have you had any special testing? (circle)
X-ray MRI CT Myelogram Cardiac Other:_____
Do you wear?: glasses/contacts orthotics mouth appliance
Have you had?: Orthodontics vision correction surgery

What is your occupation? _____ Currently working? Yes / No
Do you have any work restrictions? Yes / No If yes, what? _____
Sports or activities you are involved in: _____
What are your goals of therapy today? _____