ADVANCED TRAINING AND REHAB

Physical Therapy and Sports Specific Fitness Training

Patient Medical History

(information for Therapist use only – not intended for office use)

Name:____

Referring Physician:____

1. Have you had any visits to a Physical Therapist or Chiropractor this year? YES NO
2. If so, how many?__________________________
3. Are you currently taking any prescription or non-prescription medications? YES NO
4. List medications:

____

____

5. Please list any allergies:____

____

6. Please circle any of the following Medical or Rehabilitative Services you have received for this injury/incident:

Chiropractor	General Practitioner	Neurologist	Orthopedist
Podiatrist	CT Scan	X-rays	MRI

7. Do you currently or previously have any history of the following items?

_____Breathing difficulties	_____Vision or Hearing Difficulties
_____Chest Pain	_____Bowel or Bladder Problems
_____High Blood Pressure	_____Numbness or Tingling
_____Heart Attack or Surgery	_____Severe or Frequent Headaches
_____Pacemaker	_____ Joint Replacement
_____Stroke	_____Pins or metal implants
_____Blood clot/Emboli	_____Cancer/Chemotherapy/Radiation
_____Diabetes	_____Sleeping Difficulties
_____Osteoporosis	_____Emotional/Psychological Difficulties

8. Please list any previous surgeries and dates:____

____

9. Is there any chance you may be pregnant or are currently expecting a child? YES NO

SIGNATURE ____ DATE ___________________________

Patient or parent/guardian of minor child