

PATIENT HISTORY FORM

Name _____ Sex _____ Date of Birth _____

Please complete all required information. Use reverse side, if needed, for additional space

1. Have you ever had?

High Blood Pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>	Breathing Problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Heart Trouble	No <input type="checkbox"/> Yes <input type="checkbox"/>	Fracture	No <input type="checkbox"/> Yes <input type="checkbox"/>
Circulation Problems	No <input type="checkbox"/> Yes <input type="checkbox"/>	Stroke	No <input type="checkbox"/> Yes <input type="checkbox"/>
Seizures	No <input type="checkbox"/> Yes <input type="checkbox"/>	Arthritis	No <input type="checkbox"/> Yes <input type="checkbox"/>
Dizzy Spells	No <input type="checkbox"/> Yes <input type="checkbox"/>	Acrophobia	No <input type="checkbox"/> Yes <input type="checkbox"/>
Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>	Claustrophobia	No <input type="checkbox"/> Yes <input type="checkbox"/>
Other Illness	No <input type="checkbox"/> Yes <input type="checkbox"/>		

2. Have you ever had Surgery? No Yes If yes, give Date(s), Operation(s), and Outcome(s)

3. Do you have any metal anywhere in your body (other than your teeth)? No Yes

4. Do you have a Cardiac (heart) Pacemaker? No Yes

5. (For Women Only) Are you now pregnant? No Yes Date of last period _____

6. List medical tests done for this condition _____

7. List any Allergies you have _____

8. List any Medications you are now taking _____

9. Have you ever had Physical Therapy treatments before? No Yes

If Yes, indicate Where, When, and for What problem _____

10. Describe briefly the history of your present accident or illness _____

11. Please list any past or present medical conditions you have _____

12. Please list prior accidents or work injuries _____

13. Work Status Regular Duty Light Duty Off Duty

Date

Signature

If not Patient, indicate relationship (Parent, Guardian, Other)
