PRINT

Theresa Plasencia Physical Therapy Health and Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

NAME:_____ Date of Birth:_____

LEISURE ACTIVITIES:_____OCCUPATION:_____

ALLERGIES: List any medication(s) you are allergic to:_____

Are you latex sensitive? YES NO List any other allergies we should know about_____

Please check any of the following whose care you're under

___Medical doctor (MD) ___Psychiatrist/Psychologist Other_____

___Osteopath ___Physical Therapist _____

___Dentist ___Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

_____

_____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind:_____
YES NO Heart Problems
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical dependency (i.e., alcoholism)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy
YES NO Other

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FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery of hospitalization:

DATE REASON FOR SURGERY/HOSPITALIZATION

1._____ 2._____

3._____ 4._____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart Disease
YES NO High blood pressure
YES NO Stroke
YES NO Kidney disease
YES NO Alcoholism (chemical dependency)
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental illness

Which of the following OVER-THE-COUNTER medications have you taken in the last week?
YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamin supplements
YES NO other _

Please list any PRESCRIPTION medication you are currently taking:

_____

How much caffeine containing beverages do you drink per day? ___

How many packs of cigarettes do you smoke a day?___

How many days per week do you drink alcohol?___

Have you recently noted:

YES NO weight loss/gain
YES NO nausea/vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling

For office use

YOUR GOALS for physical therapy include:

_____

_____

Patient Signature:_____ Date_____