

PATIENT HISTORY FORM

Name _____ Sex _____ Date of birth _____

Please complete all requested 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"/>	Fractures	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"/>		No <input type="checkbox"/>	Yes <input type="checkbox"/>

2. Have you ever had Surgery? No ☐ Yes ☐ If yes, give Date(s), Operations(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. Do you have any trouble with Vision? No ☐ Yes ☐ Hearing? No ☐ Yes ☐

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. Do you smoke? No ☐ Yes ☐

12. Do you give permission to fax your medical records to your doctor? No ☐ Yes ☐

Date

Signature

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