RESTORATIVE
PHYSICAL THERAPY & REHABILITATION

MEDICAL HISTORY

DATE _____ / _____ / _____

NAME _____

To provide you with the highest level of care in the safest and most appropriate way possible, please fill out the following information. Your medical information is confidential and will be used strictly according to HIPAA guidelines.

Please check the box if you have been diagnosed with any of the following:

- ☐ High Blood Pressure (Hypertension)
- ☐ Diabetes
- ☐ HIV / Hepatitis
- ☐ Pulmonary Disorder
- ☐ Organ Transplant
- ☐ Joint replacement
- ☐ Other heart conditions not listed
- ☐ Current infection
- ☐ Recent fails
- ☐ Recent fracture
- ☐ Pacemaker
- ☐ CVA / Stroke
- ☐ Heart Attack (MI)
- ☐ Headaches
- ☐ Neurological Disorder
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Blood clots (DBT)
- ☐ Osteoporosis
- ☐ Seizures

Do you smoke? YES / NO

If female, are you currently pregnant? YES / NO

Blood Pressure _____ / _____ **Height (inches)** _____ **Weight (lbs.)** _____

Please list any current prescribed medications: _____

_____

_____

Please check tests performed *for conditions checked above only:*

☐ X- Ray ☐ MRI ☐ EMG ☐ CT ☐ Blood Work ☐ Bone Scan

☐ Other: _____

Please check if you have any of the following symptoms currently:

☐ Numbness ☐ Pins-and-needles sensation ☐ Pain that wakes you

☐ Recent unexplained weight loss ☐ Current Fever

SIGNATURE OF PATIENT OR GUARDIAN_____