ROCKLAND PHYSICAL THERAPY **MEDICAL HISTORY FORM**

PATIENT NAME______________________________

Are you presently being treated for any of the following conditions? Check all that apply.								
Diabetes	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Bleeding Disorder	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Fracture	☐ Yes	☐ No	Do you or have you had any of the following symptoms?		
Fainting Spells	☐ Yes	☐ No	Cancer	☐ Yes	☐ No			
Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			
Stroke	☐ Yes	☐ No	Metal implants	☐ Yes	☐ No	Productive Cough	☐ Yes	☐ No
Pregnancy	☐ Yes	☐ No	Respiratory problems	☐ Yes	☐ No	Coughing up blood	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Sudden weight loss	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis A, B, C	☐ Yes	☐ No	Loss of appetite	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Allergies	☐ Yes	☐ No	Lethargy / weakness	☐ Yes	☐ No
Back Injury	☐ Yes	☐ No	If yes, explain:__________			Night sweats	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No				Fever	☐ Yes	☐ No
EXERCISE	☐ None		☐ Moderate		☐ Daily	☐ Heavy		
WORK ACTIVITY	☐Sitting		☐ Standing		☐ Light Labor	☐ Heavy Labor		

Date of Onset/ Date of Injury (within 6 months)__________________ how did the injury occur:__________________

____

____

Have you been hospitalized for the present condition? ☐ Yes ☐ No If yes, date:______________

Have you had surgery for the present condition? ☐ Yes ☐ No If yes, date:______________

Have you received previous treatment for this problem? ☐ Yes ☐ No If yes, date:______________

If yes, please summarize____

____

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Is there currently any other health, medical or chiropractic service being rendered to you by any other agency, organization or individual? ☐ Yes ☐ No If yes, please summarize______________________________

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Last seen by treating Physician (date):__________________ Next appointment w/treating Physician:______________

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list:______________________

____

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Have you had any of the following for the present condition? ☐ EMG ☐ CT SCAN ☐ INJECTIONS ☐ MRI ☐ X-RAYS

Have you ever received Physical Therapy or Occupational Therapy services elsewhere? ☐ Yes ☐ No

If yes, where, when, and why:____

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Anything else we should know about?____

____

Patient/Guardian Signature:______________________________________ **Date:**______________