PST Specialized Physical Therapy, L.L.C.

Medical History Form

Name:_____ Date of birth:_____

Please rate your health:

____Excellent ____Good ____Fair ____Poor

Social/Health habits:

Do you currently smoke? ____yes ____no

If yes: # of packs per day ____

How many days per week do you drink beer, wine, or other alcoholic beverages, on average?

____days per week ____drinks per day

Do you exercise beyond normal daily activities and chores? ____yes ____no

If yes, how many days per week do you exercise? ____

Medical History: (Please check off any applicable conditions)

____Allergies	____Arthritis	____Blood disorders
____Broken bones/fractures	____Cancer	____Circulation problems
____Depression	____Growth problems	____Diabetes
____Head injury	____Heart problems	____High blood pressure
____Kidney problems	____Liver problems	____Lung problems
____Multiple sclerosis	____Muscular dystrophy	____Osteoporosis
____Pacemaker	____Parkinson's Dz.	____Seizures
____Stroke	____Thyroid problems	____Ulcers/stomach problems

Within the past year, have you had any of the following symptoms?

____Bowel problems	____Fever/chills/sweats	____Pain at night
____Chest pain	____Headaches	____Shortness of breath
____Coordination problems	____Heart palpitations	____Urinary problems
____Cough	____Hoarseness	____Vision problems
____Difficulty sleeping	____Joint pain/swelling	____Weakness in arms/legs
____Difficulty swallowing	____Loss of appetite	____Weight loss/gain
____Difficulty walking	____Loss of balance	____Other:_____
____Dizziness or blackouts	____Nausea/vomiting	

Have you ever had surgerys? ____yes ____no

If yes, please list and include date:_____

Medications: Do you take any medications? ____yes ____no

If yes, please list:_____

What is your goal(s) for treatment?: _____

_____

_____