river bend
PHYSICAL THERAPY & PREVENTATIVE CARE

MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

Area(s) of the body we will be treating today: _____Date of Injury: _____

Please describe your pain (eg: shooting pain/pins & needles/numbness, etc):

_____

What eases your pain? _____What makes your pain worse? _____

What are your goals for physical therapy? _____

Have you had previous treatment for this issue? (If yes- please specify further below)

PT _____ Chiropractic _____Other_____ Date of treatment _____

Please mark any of the following conditions that apply to you:

	YES	NO		YES	NO		YES	NO
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Multiple Sclerosis		
Anxiety			Fibromyalgia			Muscular Disease		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinson's		
Autoimmune Disorder			Headaches			Rheumatoid Arthritis		
Cancer			Hearing Impairment			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High Cholesterol			Speech Problems		
Chemical Dependency			High/Low Blood Pressure			Strokes		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants					

Please explain any of the above that you marked "Yes" & describe any additional conditions or precautions:

Is your injury a result of a fall in the past year? YES ○ NO ○ Have you had 2 or more falls in the last year? YES ○ NO ○

Please describe any previous surgeries or hospitalizations:

Surgery Type: **Date (month/year):**