Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check “Yes” or “No” if you have ever been told that you have…**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Allergies | Yes No  | Diabetes | Yes No  | Metal Implants | Yes No  |
| Anemia | Yes No  | Dizzy Spells | Yes No  | MRSA | Yes No  |
| Anxiety | Yes No  | Emphysema/Bronchitis | Yes No  | Multiple Sclerosis | Yes No  |
| Arthritis | Yes No  | Fibromyalgia | Yes No  | Muscular Disease | Yes No  |
| Asthma | Yes No  | Fractures | Yes No  | Osteoporosis | Yes No  |
| Autoimmune Disorder | Yes No  | Gallbladder Problems | Yes No  | Parkinsons | Yes No  |
| Cancer | Yes No  | Headaches | Yes No  | Rheumatoid Arthritis | Yes No  |
| Cardiac Conditions | Yes No  | Hearing Impairment | Yes No  | Seizures | Yes No  |
| Pacemaker/ Defibrillator | Yes No  | Hepatitis | Yes No  | Smoking | Yes No  |
| Chemical Dependency | Yes No  | High Cholesterol | Yes No  | Speech Problems | Yes No  |
| Circulation Problems | Yes No  | High/Low Blood Pressure | Yes No  | Strokes | Yes No  |
| COVID-19 | Yes No  | HIV/AIDS | Yes No  | Thyroid Disease | Yes No  |
| Currently Pregnant | Yes No  | Incontinence | Yes No  | Tuberculosis | Yes No  |
| Depression | Yes No  | Kidney Problems | Yes No  | Vision Problems | Yes No  |

**In the past 3 months have you had or currently experiencing…**

|  |  |  |  |
| --- | --- | --- | --- |
| A change in your health | Yes No  | Numbness or tingling | Yes No  |
| Nausea/vomiting | Yes No  | Difficulty swallowing | Yes No  |
| Fever/chills/sweats | Yes No  | Changes in appetite | Yes No  |
| Unexplained weight change | Yes No  | Changes in bowel or bladder function | Yes No  |
| Change in breathing/shortness of breath | Yes No  | Dizziness  | Yes No  |
| Any infection | Yes No  |  |  |

**If “Yes” to any of the above, please explain and give approximate dates. Describe any other Conditions.**

Have you had any fractures? YES NO

Have you had any surgery? YES NO

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or in the past have you smoked tobacco?

YES NO If yes, \_\_\_\_ packs \_\_\_\_ years.

Last tobacco use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? YES NO

If yes, \_\_\_\_\_ times per week.

Do you have radioactive implants? YES NO

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities do you have difficulty doing because of the problem that brought you to physical therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Weight­­­ \_\_\_\_\_\_\_\_\_\_\_

Please list your medications on the back with dosage and frequency.