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.