



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 surgeries? ___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?: _____
