Connections Physical Therapy, LLC
Patient Medical History

Patient Name ____ Today's date ___________________________

Do you have any allergies to medication, food, latex or tape? YES NO If yes, please list: ___________________________

Are you currently taking any medications? YES NO

If yes, please list: ____

Do you have a history of the following? (If yes, please circle)

KNEE SURGERY	ASTHMA	SEIZURES
HIP SURGERY	CANCER	DIZZINESS
BACK SURGERY	CHEST PAIN / ANGINA	HEAD INJURY
NECK SURGERY	THYROID DISEASE	SPINAL CORD INJURY
SHOULDER SURGERY	HIGH BLOOD PRESSURE	NUMBNESS/TINGLING
ABDOMINAL SURGERY	STROKE	MEMORY LOSS
BACK / NECK PAIN	ULCERS	HEARING LOSS
BROKEN BONES	LUNG DISEASE	VISUAL PROBLEMS
ARTHRITIS	HEPATITIS	PACEMAKER, DEFIBRILLATOR, OR OTHER METAL IMPLANTS
DIFFICULTY SWALLOWING	TUBERCULOSIS	
ANEMIA	KIDNEY DISEASE	RECENT UNEXPLAINED WEIGHT GAIN OR LOSS
DIABETES	HIV / AIDS	
DIFFICULTY BREATHING	HEADACHES	LOSS OF BOWEL OR BLADDER CONTROL

Are you pregnant? YES NO

Please comment on items you have check yes above or other medical history: (Please include dates, names of procedures, left or right side)

____
____
____

Do you have any specific limitations we should know about due to past medical history or doctors' recommendations?
YES NO IF YES, PLEASE LIST: ____

____

I agree that the above stated information is current and accurate to the best of my knowledge and I agree to notify my therapist if I have any changes in my medical condition.

____ ______________________

SIGNATURE OF PATIENT or PARENT / GUARDIAN DATE