Charlestown Physical Therapy and Health Services LLC

3939 Old Post Rd. Charlestown, RI 02813 401-364-2020

Medical/Health History

Do you have or have you ever had any of the following:

	Yes	No		Yes	No
High or Low Blood pressure			Arthritis (Location _____)		
Heart problems			Gout		
Pacemaker/Defibrillator			Osteoporosis/Osteopenia		
Cancer (Type_____)			Recent or unexplained weight loss		
Diabetes			Dizziness/Fainting		
Systemic Disorders (RA, MS, AIDS, Lyme, etc)			Headaches/Migraines (Frequency _____)		
Respiratory Condition			Bowel/Bladder problems		
Shortness of Breath			Seizures		
Psychiatric Disorder			Other _____		

Have you received any of the following tests: ☐X-Ray ☐CT Scan ☐MRI ☐Blood Work	Have you received any previous treatment for this injury from: ☐PT ☐Chiro ☐MD ☐ER

Please list any fractures/broken bones, strains/sprains, surgeries

_____

_____

Please list current medications

_____

_____

_____

Allergies? _____

Female Patients

Are you currently pregnant? Yes No Number of pregnancies _____

Please describe your activity level prior to injury (hobbies, leisure activities)

_____

_____

Please describe your goals for physical therapy

_____

_____

Do you have any concerns that may limit your ability to participate in physical therapy?

_____

_____

_____

Patient Signature (Parent or Guardian's signature if under 18) Date