

Name: _____

Age: _____

To assist your therapist in providing optimal rehabilitative care, please complete all the questions below:

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Diabetes			Chronic Headaches		
High/Low Blood Pressure			Dizziness		
Heart Disease			Vertigo		
Chest Pain			Seizures		
Pacemaker			Kidney Problems		
Shortness of Breath			Liver Problems		
Chronic Cough			Abdominal Pain		
Wheezing			Pregnancy		
Asthma			Thyroid Condition		
Do You Smoke			Metal Implants, Pins, Plates, Shrapnel, Spinal Stimulator		
Excessive Weight Loss			Fractures		
Change in Urination			Fibromyalgia		
Change in Bowel Habits			Hernia (list type)		
Cancer			Previous Therapy		
Surgeries					

If you answered **YES** to any of the above, please explain and give appropriate dates:

Do you have any allergies to: ڦ Heat/Cold ڦ Latex ڦ Massage Cream/Lotion

Other allergies: _____

Are you presently taking medication?: ڦ YES ڦ NO

If **YES**, please list what medication(s) and for what condition(s):

(Use additional space on back of form)

Have you recently experienced fever, weight loss or loss of appetite: ڦ YES ڦ NO

What are your goals for physical therapy?:
