

Physical Therapy Works

Ponte Vedra Beach, Florida

Patient Health Information

Name: _____ DOB: _____

Please put a check in the box next to any medical conditions you may have, or have had in the past.

Musculoskeletal

- Osteoarthritis
- Rheumatoid Arthritis
- Polymyalgia
- Lupus/SLE
- Fibromyalgia
- Chronic Fatigue
- Osteoporosis
- Headaches/Migraines
- Bulging Disks
- Leg Cramps
- Jaw Pain/TMJ
- History of Falls
- Cane/Walker/Crutches
- Other: _____

Circulation/Respiration

- Heart Conditions
- Heart Attack
- Heart Arrhythmias
- Pace Maker
- High Cholesterol
- Blood Clots/Phlebitis
- Anemia
- Other: _____

Digestion

- Diabetes
- Kidney Problems
- Irritable bowel
- Bladder Problem
- Liver Problem
- Hernia
- Other: _____

Nervous System

- Stroke/TIA
- Parkinson's
- Multiple Sclerosis
- Epilepsy/Seizures
- Concussion/Brain Injury
- Numbness/Tingling
- Other: _____

Infectious Disease

- TB
- Hepatitis
- Polio
- Other: _____

Skin

- Skin Allergies/Rashes
- Eczema/Psoriasis
- Infectious Skin Diseases
- Shingles
- Other: _____

Please list any other prior accidents, broken bones or surgeries with approximate dates: _____

1. Have you had surgery for this injury? YES NO If yes, Surgery date(s): _____

2. When did pain begin? (Date of Injury) _____

3. Have you had any Medical or Rehabilitative services for this injury/episode? YES NO

4. Are you currently taking any prescription or non-prescription medications? If so please list them: _____

5. List any other information that would assist us in your care: _____

6. Are you aware of what your diagnosis is? _____

7. Based upon your awareness, what are your expectations/goals while in Therapy? _____

Do you smoke? YES NO

Are you pregnant? YES NO

Patient/Guardian Signature

Date

I have reviewed contraindications with _____ prior to initiating evaluation and treatment. The following contraindications were identified:
I have reviewed with _____ their rehabilitation potential prior to initiating treatment.
Therapist Signature: _____ Date: _____