ACADEMY PHYSICAL THERAPY

Patient Name: _____

Please tell us about your current problem for which you are seeking physical therapy:

When did your current problem(s) begin? (Please list exact date, if you know. If you are not sure or if you cannot remember, please tell us the approximate year and month).____

Have you ever had the problem before? ☐ Yes ☐ No

If yes, when? _____

If you had the problem(s) before, what did you do for the problem(s) at that time?

_____

If you had the problem(s) before, did the problem(s) get better? ☐ Yes ☐ No

If you had the problem(s) before, how long did the problem last? _____

Aside from your current problem(s), list any other muscle, joint or bone problems (including fractures)

that you have had:_____

_____

Please check if you have, or have had:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Blood disorders
- ☐ Broken bones/fracture
- ☐ Cancer or tumors
- ☐ Cataracts
- ☐ Circulation/Vascular Problems
- ☐ Depression
- ☐ Developmental or Growth Problems
- ☐ Diabetes/high blood sugar
- ☐ Emphysema or other lung problems
- ☐ Gout
- ☐ Head Injury
- ☐ Heart Problems
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Hypoglycemia/low blood sugar
- ☐ Kidney problems
- ☐ Liver disease (including Hepatitis)
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Rheumatoid diseases
- ☐ Seizures/Epilepsy
- ☐ Skin Diseases
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers

For Men:

Have you ever been diagnosed with prostate disease? ☐ Yes ☐ No

For Women:

Please indicate the number of pregnancies._____

Were any of these pregnancies or deliveries complicated? ☐ Yes ☐ No

Are you currently pregnant, or do you think you might be pregnant? ☐ Yes ☐ No

Have your ever been diagnosed with pelvic inflammatory disease? ☐ Yes ☐ No

 **PLEASE COMPLETE THE BACK PAGE** 

Are you allergic to latex? ☐ Yes ☐ No
If you are allergic to any foods, drugs or other substances, please list them here: _____

_____

If you have ever had surgery, please describe and give dates: **Month** **Year**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any medications you are currently taking (If you taking pain medication; please give the dosage)

_____

_____

_____

_____

Please check any of the following that you have experienced in the past year (check all that apply)

- ☐ Chest pain
- ☐ Coordination problems
- ☐ Cough
- ☐ Difficulty going to the bathroom
- ☐ Difficulty sleeping
- ☐ Difficulty swallowing
- ☐ Dizziness or blackouts
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart palpitations
- ☐ Hoarseness
- ☐ Joint pain or swelling
- ☐ Loss of appetite
- ☐ Loss of balance
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Vision problems
- ☐ Weight loss or gain

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks do you have per week? _____

Do you smoke (cigarettes or cigars)? ☐ Yes ☐ No
If yes how many per day? _____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been accurately answered. I understand that by providing incorrect medical information can be dangerous to my health.

X_____
Signature of patient (or parent of minor) **Date**