Print Name:

PEAK PHYSICAL THERAPY
PERSONAL MEDICAL HISTORY FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

1. Circle all that apply and explain the following medical problems that you currently have or have had:

AIDS/HIV	Dizziness	Motor Vehicle Accident
Allergies	Difficulty Swallowing	Nausea/Vomiting
Anemia	Drug Abuse	Night Pain
Anxiety	Emphysema	Numbness/Tingling
Arthritis	Fainting	Osteoperosis/Osteopenia
Asthma	Fever/Chills/Sweats	Psychiatric Treatment
Back Trouble	Fibromyalgia	Ringing in Ears
Bronchitis	Fractures	Rheumatic Fever
Bleeding Disease	Glaucoma	Rheumatic Heart Disease
Blood clots	Head Aches	Seizures
Cancer	Heart Disease	Shortness of Breath
Change in Bowel/Bladder Function	Heart Attack	Sinusitis
Change in Vision	Heart Murmur	Stomach Ulcers
Chest Pain/ Angina	Hepatitis	Stroke
Congenital Heart Defect	Herpes	Swelling of Hands / Feet
Congestive Heart Failure	High/Low Blood Pressure	Thyroid Disease
Convulsions	Jaundice	Tuberculosis
COPD	Kidney Disease	Other:
Diabetes	Liver disease	
Depression	Loss of Balance/ Falls	

2. List any operations or surgeries that you have had:

3. Reasons for being referred to physical therapy:

A. Body part/area hurt or type of injury:

B. When did this injury occur?:

C. How were you injured?:

i. Is this injury a result of a workplace accident? **Y N**
ii. Is this injury a result of a motor vehicle accident? **Y N**
iii. Have you had surgery for this injury (if so what/when)? **Y N**
iv. Have you had a cast removed from this injured body part in last 2 weeks? **Y N**
v. Have you had physical therapy for this same injury in the recent past? **Y N**
vi. Have you previously injured this body area before (if so explain)? **Y N**

4. List any medications you are currently taking:

OVER

5. List any allergies and describe any drug reactions:

_____

_____

6. Please circle any of the following you may have/wear:
Glasses Contacts Dentures Pacemaker Metal/Foreign Object Implant

7. Are you pregnant? Yes No

8. Any significant weight gain/loss in the last year? Yes No (+-)_____lbs

9. Are you under the care of any other medical/health provider or physician? Yes No

If yes, for what condition are you being treated? 1) _____

2) _____ 3) _____

10. What do you expect to gain/accomplish in receiving physical therapy?

_____

_____

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.

Signature:_____ Date:_____