

## MEDICAL HISTORY

Referring Physician: \_\_\_\_\_ Next MD Appointment: \_\_\_\_\_

Please fill out as accurately as possible. Space is provided below for explanations if necessary. Your answers are designed to provide the therapist with the necessary information to ensure your safety and treatment effectiveness.

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

	YES	NO
High or low blood pressure		
Heart problems or cardiac irregularities		
Family history of cardiac problems		
Pacemaker or metal implants		
Cancer (indicate type)		
Family history of cancer		
Recent unexplained weight loss		
Diabetes (Type 1 or 2)		
Systemic disorders (i.e. RA, MS, AIDS, etc)		
Allergies, including latex or medication		
Respiratory ailments		
Intestinal organ problems (stomach, kidneys, etc)		
Osteoporosis		
Alcohol or drug addiction		
Neck strain		
Low back pain		
Fractures		
Arthritis (indicate joint)		
Ligament sprain, muscle strain		
Do you smoke?            If so, how much?		

Please explain the YES answers:

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Please list any medications you are taking:

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Please list any other significant ailments or problems that have required medical treatment in the past:

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Please list any ailment for which you are currently undergoing treatment:

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Please list any surgeries, including dates:

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Are you under any specific instructions or precautions from a physician?

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Do you have any precautions concerning exercise or physical activity?

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Female patients: Is there any chance you could be pregnant? \_\_\_\_\_

*Sign below to indicate you have answered all questions accurately and to the best of your ability.*

\_\_\_\_\_ Date: \_\_\_\_\_