PHYSICAL THERAPY HISTORY INTAKE

Please answer the following questions regarding your medical history. Have you ever had following?

Heart problems? Yes □ No □
Explain_____

Cancer? Yes □ No □
Explain _____

Diabetes? Yes □ No □
Explain _____

High blood pressure? Yes □ No □
Explain_____

Blood/ circulatory problems? Yes □ No □
Explain _____

Fractures? Yes □ No □
Explain _____

Muscle/ joint problems? Yes □ No □
Explain _____

Breathing problems (ex: asthma, bronchitis, etc) ? Yes □ No □
Explain _____

Are presently taking any medications? Yes □ No □
Explain _____

Do you have any orthopedic (bone, joint, muscle) problems that restrict or limit your physical activity in any way? Yes □ No □
Explain _____

Have you ever had surgery for any reason? Yes □ No □
Explain _____

Do you drink, smoke or have any other dependencies? Yes □ No □
Explain _____

Do you have any allergies? Yes □ No □
Explain _____

Have you previously had Physical Therapy? Yes □ No □
Reason _____Location_____

Patient's signature_____Date:_____