Name: ____ Age:_____________

Primary Care Physician: _________________________________ Occupation: ________________

In addition to your referring physician, would like your PT/OT notes sent to your PCP? Yes ☐ No ☐

Have you **EVER** been diagnosed as having any of the following conditions? (Please circle)

Yes No AIDS/HIV
Yes No Anemia
Yes No Asthma
Yes No Back or Neck History. If Yes, describe ____
Yes No Blood Clots
Yes No Cancer If Yes, what kind? ____
Yes No Cholesterol
Yes No Circulation Problems
Yes No Concussion
Yes No Diabetes If yes, do you carry glucose tablets? ____Ever had a low sugar attack? ____
Yes No Fractures or Orthopedic Injury ____
Yes No Emphysema /COPD
Yes No Epilepsy/Seizures
Yes No Gastric Reflux/GERD
Yes No Heart Problems If Yes, be specific/describe_______________________________________
Yes No Hepatitis If Yes, what type ____
Yes No High Blood Pressure
Yes No Incontinence
Yes No Kidney Disease
Yes No Multiple Sclerosis (MS)
Yes No Other arthritic conditions/Osteoporosis/Osteopenia (If Yes, please circle one)
Yes No Pregnant (currently)
Yes No Psychiatric History If Yes, describe ____
Yes No Rheumatoid Arthritis
Yes No Stroke
Yes No Syncope/Fainting
Yes No Thyroid Problems If Yes, describe ____

Please list ALL other Medical Conditions or Allergies ____

____

Please list <u>Previous Surgeries</u> or <u>any other conditions</u> for which you have been hospitalized:

Date (approximate)	Surgery/Reason for Hospitalization
_________________	____
_________________	____
_________________	____
_________________	____

Please Continue to the Next Page

Have you fallen in the past 3 months? Yes ☐ No ☐ If yes, describe how____

Do you have any metal implants or fusions? Yes ☐ No ☐

If yes, where?____

Do you have any electrical implants? (eg. Pacemaker or Defibrillator) Yes ☐ No ☐

Smoking? If so, how often ____

Have you ever been to physical or occupational therapy in the past year? ______________________________________

PLEASE LIST ALL MEDICATIONS

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