

Physical Therapy First, L.L.C. Medical History (Confidential)

Date _____ Account No. _____

Patient Name (Last, First, MI) Date of Birth Social Security No.

Allergies: None _____

Current Medications: None _____

Surgeries And Dates: None _____

Conditions Currently Being Treated: None _____

Previous Orthopedic Injuries: None _____

Please check all that apply and give date of onset:

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Seizure
<input type="checkbox"/>	Asthma / Allergies	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Substance Abuse
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Pulmonary Disease	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	

Signature of Patient / Guardian Date

Name of Patient / Guardian

HABITS			EXERCISE
<input type="checkbox"/> Smoking	Packs/Day	___	<input type="checkbox"/> None
<input type="checkbox"/> Drinking	Alcohol	___	<input type="checkbox"/> Moderate
<input type="checkbox"/> Coffee	Cups/Day	___	<input type="checkbox"/> Daily

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?			
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles	<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Infection	<input type="checkbox"/> AIDS
GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR/NOSE/THROAT	RESPIRATORY
<input type="checkbox"/> Headache	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Fever	<input type="checkbox"/> Poor Digestion	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Spitting Blood
<input type="checkbox"/> Chills	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Belching or Gas	<input type="checkbox"/> Deafness	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Earache	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Ear Noises	
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Ear Discharge	GENITO-URINARY
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Pain over Stomach	<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Numbness or pain in arms, legs, or hands	<input type="checkbox"/> Hemorrhoids (Piles)	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Inability to control Urine
<input type="checkbox"/> Allergy	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Asthma	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Frequent Colds	
<input type="checkbox"/> Neuralgia	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Enlarged Thyroid	
		<input type="checkbox"/> Sinus Trouble	

MUSCLES & JOINTS	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR WOMEN ONLY
<input type="checkbox"/> Weakness <input type="checkbox"/> Twitching <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Backache <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Tremors <input type="checkbox"/> Foot Trouble	<input type="checkbox"/> Rapid Heart <input type="checkbox"/> Slow Heart <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Pain over Heart <input type="checkbox"/> Previous Hear Trouble <input type="checkbox"/> Swelling Ankles	<input type="checkbox"/> Skin Eruptions <input type="checkbox"/> Itching <input type="checkbox"/> Bruising Easily <input type="checkbox"/> Dryness <input type="checkbox"/> Boils <input type="checkbox"/> Sensitive Skin <input type="checkbox"/> Hives or Allergy	<input type="checkbox"/> Currently pregnart <input type="checkbox"/> Painful Periods <input type="checkbox"/> Excessive Flow <input type="checkbox"/> Irregular Cycles <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Cramps or Backaches <input type="checkbox"/> Miscarriage