MEDICAL HISTORY

Patient Name _____

Are you in good health? Yes _____ No _____
Are you now under the care of a physician? Yes _____ No _____
If so, what condition is being treated? _____
Have you been treated with physical therapy since January 1, 2017? Yes _____ No _____

Do you, or have you had any of the following?

YES	NO	
_____	_____	Tire easily, Weakness
_____	_____	Marked weight change
_____	_____	Diabetes
_____	_____	Family history of stroke
_____	_____	Stroke
_____	_____	Heart Attack, Heart Trouble
_____	_____	Heart Murmur
_____	_____	High Blood Pressure
_____	_____	Low Blood Pressure
_____	_____	Artificial Heart Valve
_____	_____	Pacemaker
_____	_____	Heart Surgery
_____	_____	Artificial Joints
_____	_____	Blood Transfusions
_____	_____	Cancer
_____	_____	Bleeding Problems
_____	_____	Rheumatic Fever
_____	_____	Tuberculosis
_____	_____	Asthma
_____	_____	Arthritis
_____	_____	Allergies
_____	_____	Hepatitis
_____	_____	Women – Are you pregnant?

CACC PHYSICAL THERAPY

Have you ever experienced any reaction to the following?

_____	_____	Penicillin
_____	_____	Aspirin
_____	_____	Others
_____	_____	Are you taking any medication? If so, please list: _____ _____
_____	_____	Have you been hospitalized in the past five years? If so, for what condition? _____
_____	_____	Do you have any other medical condition of which we should be made aware? If so, please explain: _____
_____	_____	Have you ever had low back pain? If so, how many times? _____

What, if any, sports/activities do you do for exercise?

_____

IF THERE IS ANY CHANGE IN YOUR HEALTH OR MEDICATION, PLEASE INFORM US!