Lifestyle Physical Therapy, Inc.
Patient Medical History

Name: _____ **Referring Physician:** _____
Have you had Surgery for this injury: YES _____ NO_____

Are you currently taking any prescription or non-prescription medications (including herbals, vitamins, over the counter, or nutritional supplements). Please provide a list of the medication name, dosage, frequency and route. What physician prescribed the medication?

_____
_____
_____
_____
_____

Have you had any of the following Medical or Rehabilitative Services for this Injury/ Episode?

	YES	NO		YES	NO
Chiropractor	_____	_____	CT Scan	_____	_____
EMG/ NCV	_____	_____	General Practitioner	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Myelogram	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	Podiatrist	_____	_____
Emergency Room Care	_____	_____	X-rays	_____	_____

Other_____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema	_____	_____	Severe or Frequent Headaches	_____	_____
Shortness of Breath/ Chest Pain	_____	_____	Vision or Hearing Difficulties	_____	_____
Coronary Disease / Angina	_____	_____	Numbness or Tingling	_____	_____
Do you have a Pacemaker?	_____	_____	Dizziness or Fainting	_____	_____
High Blood Pressure	_____	_____	Pins or Needles	_____	_____
Heart Attack or Surgery	_____	_____	Weakness	_____	_____
Stroke/ TIA	_____	_____	Weight Loss/ Energy Loss	_____	_____
Blood Clot/ Emboli	_____	_____	Hernia	_____	_____
Epilepsy/ Seizures	_____	_____	Varicose Veins	_____	_____
Thyroid Trouble / Goiter	_____	_____	Allergies	_____	_____
Anemia	_____	_____	Any Pins or Metal Implants	_____	_____
Infectious Diseases	_____	_____	Joint Replacements	_____	_____
Diabetes	_____	_____	Neck Injury/ Surgery	_____	_____
Cancer or Chemo/ Radiation	_____	_____	Shoulder Injury/ Surgery	_____	_____
Arthritis/ Swollen Joints	_____	_____	Elbow /Hand Injury/ Surgery	_____	_____
Osteoporosis	_____	_____	Back Injury/ Surgery	_____	_____
Gout	_____	_____	Hip/Knee Injury/ Surgery	_____	_____
Sleeping Problems/ Difficulties	_____	_____	Ankle/Foot Injury/ Surgery	_____	_____
Emotional/Psych. Problems	_____	_____	Are you Pregnant?	_____	_____
Bowel or Bladder Problems	_____	_____	Do you Smoke?	_____	_____

List any other information that would assist us in your care:

_____

Patient/ Guardian Signature: _____ **Date:** _____