Healthy Body Physical Therapy

Medical History Form

First Name: ______________________________ Last Name: ___________________________

Height: ____ ft ____ in Weight: _____ (pounds)

Have you ever, or are you presently being treated for any of the following conditions?

Yes ☐ No ☐ Any Heart condition
Yes ☐ No ☐ High or Low Blood Pressure
Yes ☐ No ☐ High Cholesterol
Yes ☐ No ☐ Any Respiratory condition
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Angina
Yes ☐ No ☐ Anxiety/Panic Disorder
Yes ☐ No ☐ Depression
Yes ☐ No ☐ Multiple Sclerosis
Yes ☐ No ☐ Bleeding disorder
Yes ☐ No ☐ Hernia
Yes ☐ No ☐ Pregnancy
Yes ☐ No ☐ Pacemaker
Yes ☐ No ☐ Nausea/Vomiting
Yes ☐ No ☐ Skin Abnormalities
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ GI/Bowel/Bladder abnormality
Yes ☐ No ☐ Allergies
Yes ☐ No ☐ Headaches
Yes ☐ No ☐ Stroke or TIA
Yes ☐ No ☐ Epilepsy
Yes ☐ No ☐ Hearing Impairment
Yes ☐ No ☐ Visual Impairment
Yes ☐ No ☐ Kidney problems
Yes ☐ No ☐ Liver/Gallbladder problems
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Hepatitis A, B, C
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Metal implants
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Osteoporosis
Yes ☐ No ☐ Fracture
Yes ☐ No ☐ Back Pain/Back Injury

If you answered yes to any of the above conditions please provide details: _______________

____

Is there any other information regarding your medical history we should know about?

____

List any medication you may be taking: ______________________________________

____

Please indicate any past or current injury you may have: ___________________________

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Have you received previous treatment for this condition? Yes ☐ No ☐

If Yes, please explain: ____