bodworks
PHYSICAL THERAPY

Medical History Form

Today's Date:_____

Patient name:(print)_____**DOB:**_____

Check all that apply:

□ Diabetes	□ Heart Condition	□ High Blood Pressure	□ Dizziness
□ Seizures	□ Cancer/Tumor	□ Rheumatoid Arthritis	□ Osteoarthritis
□ Osteopenia	□ Osteoporosis	□ Depression/Anxiety	□ Asthma
□Edema	□ Thyroid Disorder	□ Fibromyalgia	□ Latex Allergy
□ Pacemaker	□ Recent weight loss	□ Change in bowel/bladder	□ Anaphylaxis
□ Pregnancy - wks _____		□ Other _____	

List any surgeries you have had: _____

_____

List any medications/supplements you currently take:_____

_____

_____

What is your primary reason for seeking physical therapy? _____

Describe your symptoms:

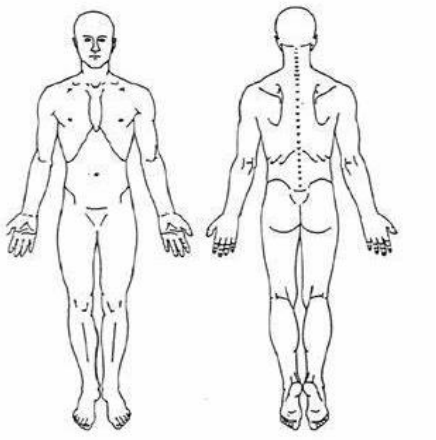
□ Ache	□ Numbness/tingling	□ Dull pain	□ Sharp pain
□ Shooting	□ Throbbing	□ Burning	□ Other _____

Please rate your pain (0= no pain; 10= worst possible pain)

0	1	2	3	4	5	6	7	8	9	10

No pain ***Moderate pain*** ***Worst possible pain***

Please mark the body chart with an X in the areas of pain



List any additional health information you would like us to know:

_____

_____

_____

_____