PATIENT MEDICAL HISTORY

Name:_____ Age:_____

Occupation:_____ Work Status:_____

Please check the following conditions as they appy to you:

CONDITIONS	YES	NO	EXPLANATION
Allergies			
Heart Disease			
High Blood Pressure			
Diabetes			
TB			
Hepatitis			
Rheumatoid Arthritis			
Cancer			
Pacemaker			
Stroke			
Severe Dizziness			
Kidney Disorders			
Blood Disorders			
Osteoporosis			
Deep Vein Thrombosis			
Fibromyalgia			
Chronic Fatigue Syndrome			
Gastrointestinal			
Weight loss or gain			
Difficulty swallowing			
Thyroid disorder			
Eating disorder			
Lupus			
Psoriatic arthritis			
Ankylosing spondylitis			
Seizures			
Multiple sclerosis			
Traumatic head or brain injury			
sleep dysfunction: insomnia			

Place an **X** on the pain scale that shows your pain level.

List chief complaint:_____

Have you had any imaging for this condition:

Xrays	Y	N
MRI	Y	N
CT	Y	N

Date of last complete medical exam:_____

Health Care Provider:_____

Have you had any past or present surgical procedures? Y N

If YES, please list: _____

_____

How many hours of sleep do you get per night?_____

Do you wake frequently at night? Y N

If so, how often?_____

Do you have a bladder condition? Y N

Frequent urination? Y N

Leakage with coughing, laughing, sneezing? Y N

Do you feel you are under a lot of stress? Y N

Do you exercise on a regular basis? Y N

list activity, frequency and duration: _____

_____

Are you currently pregnant?_____ Or been in the last year?_____

Do you smoke? Y N How many packs per day?_____

Do you drink alcohol? Y N How often?_____

Have you ever been treated for depression or psychological problems? (optional)
If yes, please explain:

If YES, please list:

Name of Medication	Dosage	Frequency

Signature:

Date:

CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for MOFFETT PHYSICAL THERAPY to furnish medical care and treatment to myself or _____ considered necessary and proper in diagnosing or treating my physical condition.

Patient/Guardian Signature

Date