PATIENT HISTORY FORM
SPINE & SPORT PHYSICAL THERAPY

Patient Name: _____ Gender: _____ Date of Birth: _____

Have you ever experienced or been diagnosed with any of the following:

	Yes	No		Yes	No
High Blood Pressure			Headaches		
Heart Trouble			Rheumatic Disease		
Circulation Problems			Seizures		
Blood Clots			HIV/AIDS		
Stroke			Cancer		
Dizzy Spells			Hepatitis		
Breathing Problems			Mental Illness		
Fractures			Fibromyalgia		
Osteoporosis			Diabetes		
Arthritis			Sudden Weight Loss/Gain		
Hearing Change/Problems			Tuberculosis		
Vision Change/Problems			Other:		

Height: _____ Weight: _____

Have you ever had Surgery? Yes No

If yes, give date(s) and operation(s)_____

_____

Do you have any metal in your body (other than your teeth)? Yes No

Do you have a Cardiac (heart) Pacemaker? Yes No

(For Women) Are you currently pregnant? Yes No Date of last period_____

List any Allergies you have_____

Have you ever had physical therapy treatments before? Yes No

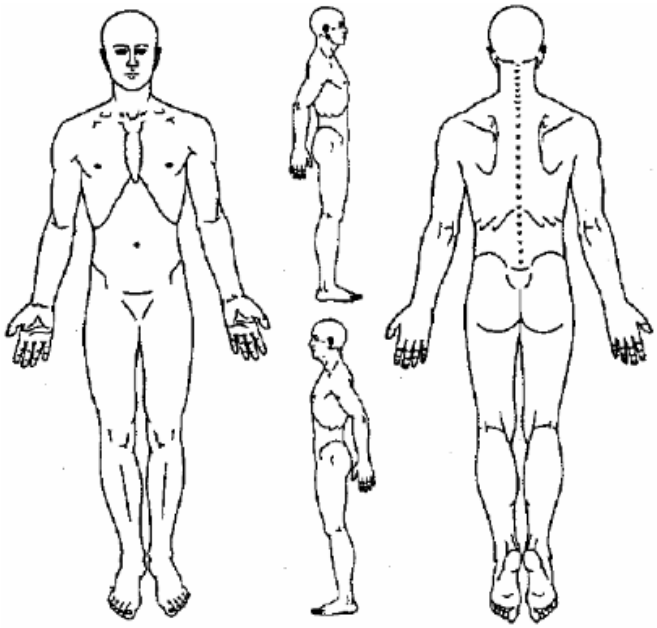
If yes, indicate Where, When and for What problem_____

_____

Describe briefly the history of your present accident/illness/injury_____

_____

Please use XXXX's to indicate on the diagram where you are currently experiencing pain and ////'s where you are experiencing numbness or tingling.



Do you smoke? Yes No
Packs per day_____ Since_____

Do you drink? Yes No
How many drinks per day_____ per week_____

Do you exercise? Yes No
How many days per week _____ How long per session _____

What type of exercise_____

Work: Employed Unemployed Retired Disabled

Current Occupation:_____

Hobbies: _____

Do you give permission to fax your medical records to your doctor? Yes No

_____ _____

Signature **Date**

If not Patient, indicate relationship (Parent, Guardian, Other)