StartClinic

Physical Therapy Center

Name ____
Please Print

Have you previously received physical therapy for your current injury/condition(s) or other condition(s) at any other time: _____no _____yes, please explain:

Date Facility for what condition

____

____

Do you or have you had any of the following:

Allergies	____yes	____no	Kidney problems	____yes	____no
Diabetes	____yes	____no	Metal implants	____yes	____no
Headaches	____yes	____no	Nervous disorders	____yes	____no
Heart Attacks/Disease	____yes	____no	Pacemaker	____yes	____no
Hernia	____yes	____no	Positive TB skin test	____yes	____no
High blood pressure	____yes	____no	Seizures	____yes	____no
Immune compromised	____yes	____no	Sensitive to heat/cold	____yes	____no
Surgery	____yes	____no			

Other Medical conditions:____

If yes to any of the above, please explain: ______________________________

____

____

Are you currently taking any medications? What are their names and for what condition(s) are they treating?_______________________________________

____

____

I have read and understand the above information and have accurately answered to the best of my knowledge. I understand that providing incorrect information can hinder the success of my physical therapy treatment.

Signature____Date__________________