ENCHANTED LAKE PHYSICAL THERAPY

MEDICAL HISTORY

Name: _____ □Male □Female Date: _____

Are you presently working? □Yes □No If No, last day worked: _____ Plan to return to work: _____

If Yes, working □full duty □light duty Restrictions: _____ Hours working: _____

Previous hospitalization/surgeries/serious illness (list & date): _____

_____

Current Medications (including non-prescription): _____ _____

_____

Have you ever been diagnosed for any of the following conditions (check all that you ever had):

□Aids/HIV
□Cancer
□Diabetes
□Respiratory/Lung Problems
□Kidney/Liver Problems
□Bladder Problems
□High Blood Pressure
□Heart Conditions (Angina/Chest Pains, Pacemaker etc.)
□Orthopedic (Fracture, arthritis etc.)
□Osteoporosis
□Metal Implants
□Fibromyalgia
□Muscular Dystrophy
□Deep vein thrombosis
□Gout
□Other: (please list): _____
□Headaches
□Neurological Conditions (Seizures, MS, Parkinson's Disease, Stroke, etc)
□Anxiety/Depression
□Allergies (Heat, Cold, Skin etc.)

Have you had a recent illness or a medical condition(s) noted above that would be affected by physical exercises (if yes, explain)?_____

Is there medical clearance in chart? □Yes □No

Do you take blood thinners? □Yes □No

Are you allergic to latex? □Yes □No Other allergies (please list): _____

Females: Are you pregnant? □Yes □No If yes, due date: _____

Do you smoke? □Yes □No

Currently I am experiencing (circle all that apply):

Fever/chills/sweat	Poor Balance (falls)	Unexplained weight loss	Numbness or Tingling	Depression
Changes in Appetite	Difficulty Swallowing	Shortness of Breath	Headaches	Dizziness
Nausea/Vomiting	Increased pain at Night	Changes in bowel or bladder function		

Check any of the following activities which you have difficulty with due to your current condition or injury:

□Housekeeping	□Lifting	□Walking	□Driving	□Reaching	□Sleeping
□Dressing	□Cooking	□Climbing Stairs	□Child Care	□Bending	□Work Duties
□Yard Work	□Sit to Stand	□Standing	□Sitting	□Recreational activities: _____	
□Other: _____				_____	

To the best of my knowledge, this information is correct and accurate.

_____ _____ _____

Patient / Parent / Guardian Signature Relationship to Patient Date

Thank you for taking the time to fill this out as thoroughly and accurately as possible.