PREMIER
PHYSICAL • THERAPY

Past Medical History

Patient Name: _____ DOB: _____Age: ____ Date: _____

Medical History

Do you have a history of:	Yes	No		Yes	No
Alzheimer's	___	___	History of Cancer	___	___
Cardiovascular Disease	___	___	Huntington's Disease	___	___
Cauda Equina Disease	___	___	Immunosuppression	___	___
Cerebral Vascular Accident	___	___	Lupus	___	___
Current Infection	___	___	Muscular Dystrophy	___	___
Diabetes Mellitus Type 1	___	___	Obesity	___	___
Diabetes Mellitus Type 2	___	___	Osteoarthritis	___	___
Fibromyalgia	___	___	Parkinson's	___	___
Fracture or Suspected Fracture	___	___	Rheumatoid Arthritis	___	___
High Blood Pressure	___	___	Traumatic Brain Injury	___	___
Other(explain) _____			Incontinence	___	___
_____					

Personal History

Do you have a history of:	Yes	No	Explanation
Allergies	___	___	_____
Alcohol Consumption	___	___	_____
Smoking	___	___	_____
Previous Physical Therapy	___	___	_____
Depression	___	___	_____
PTSD	___	___	_____

How did the injury occur? _____

Are there multiple treament areas? **Yes** **No** Explain: _____

Past Surgeries and dates: _____
_____

Time or Onset of Pain: _____

Do you have an attorney representing you as a result of your injury? **Yes** **No** Who?_____

List of current medications: _____
_____
_____

Patient Signature: _____ Date: _____