MEDICAL INFORMATION FORM

Today's Date: _____

Name: _____Age: _____ Occupation: _____
Who referred you to us? (Physician, etc)_____
Reason for visit: □ Physical Therapy / Injury Rehabilitation □ Personal Training / Wellness Program
Goals: _____

Current Problem Information:

Date of Injury / Onset: _____ Is this a Work Related Injury? □ Yes □ No
Body Part(s) Affected:_____
How Did This Happen? _____
What does it feel like now?: _____
_____
What makes it worse or better?_____
Have you had any treatment yet? (If so, what): _____
Have you had any testing? (circle which) X-Rays MRI other_____
Have you had any recent illness?: _____Treatment?: _____

Lifestyle Information

Current Health Status: Excellent □ Good □ Fair □ Poor□
What does your work require you to do?_____
What Sport, Exercise, or Activities do you want to do? _____
_____
Prescriptions / Medications: _____
Vitamins or Nutritional Supplements: _____
Sleep Average (hours): _____Daily Water Intake_____ Alcohol**?:** Y N If yes, how much: _____
Caffeine**?**: Y N If yes, how much: _____ Tobacco**?:** Y N If yes, how much:_____
Describe your Dietary habits:_____

Past Medical & Surgical Information

1. _____
2. _____
3. _____
4. _____

Medical Conditions (you have or had)

Asthma	Headaches	Fatigue
Breathing Problems	Dizziness	Fever/chills/sweats
Emphysema	Tingling / Numbness	Chemical Dependency
Tuberculosis	Fainting	Sexual dysfunction
Heart Attack	Nausea / Vomiting	Urinary changes
Heart Disease	Neurologic Disorder	Bowel dysfunction
Stroke	Epilepsy	Eating Disorder
Kidney Disease	Multiple sclerosis	Hernia
Circulatory Disease	Depression	Pregnancy
High Blood Pressure	Thyroid Problems	Hepatitis
Diabetes	Constipation	
Arthritis	Cancer	
Metal / other implant	Night pain	
Osteoporosis	Unexplained weight change	