Kelly Hawkins
Physical Therapy

Patient Medical History

Name:_____Referring Physician:_____
Date of Injury:_____Date of next Doctors visit for this injury:_____
Have you had surgery for this injury:____Yes____No Date of Surgery:_____
Are you currently taking any prescription or non prescription medications?: ____Yes ____No
Please list all medications you are currently taking, please include dosage:_____
_____
_____
_____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Numbness or Tingling	____	____
Shortness of breath/Chest Pain	____	____	Dizziness or Fainting	____	____
Coronary artery disease or angina	____	____	Bowel or Bladder problems	____	____
Do you have a pacemaker?	____	____	Weakness	____	____
High blood pressure	____	____	Weight loss/Energy loss	____	____
Heart Attack or Surgery	____	____	Hernia	____	____
Stroke/TIA	____	____	Varicose Veins	____	____
Congestive Heart Disease	____	____	Allergies	____	____
Blood Clot/Emboli	____	____	Any pins or metal implants	____	____
Epilepsy/Seizures	____	____	Joint replacement surgery	____	____
Thyroid Disease or Goiter	____	____	Neck Injury/Surgery	____	____
Anemia	____	____	Shoulder Injury/Surgery	____	____
Infectious diseases	____	____	Elbow/Hand Injury/Surgery	____	____
Diabetes	____	____	Back Injury/Surgery	____	____
Cancer or Chemotherapy	____	____	Knee Injury/Surgery	____	____
Arthritis	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Osteoporosis	____	____	Are you pregnant?	____	____
Gout	____	____	Do you use tobacco?	____	____
Sleeping Problems/Difficulties	____	____	If yes how long have you used tobacco?		___
Emotional/Psychological Problems	____	____	_____		
Severe or frequent headaches	____	____	How often do you use tobacco?		_____
Vision or hearing difficulties	____	____	_____		

List any other information that would assist us in your care:_____
_____
What are your rehabilitation expectations/goals while in this program?_____
_____
_____

Patient/Guardian Signature:_____Date:_____