Southwest Center
Physical Therapy
& Rehabilitation

MEDICAL HISTORY

Patient Name _____

Reason for therapy or testing

_____

_____

Date of injury or onset _____

Diagnostic tests and results

_____

_____

Previous treatment received (what, when, where ?)

Physical Therapy _____

Surgery _____

Other _____

Check any and all conditions listed below that you now have or ever had.

__ High blood pressure	__ Migraine headaches	__ Arthritis
__ Diabetes	__ Heart disease	__ Pacemaker
__ Vascular disease	__ Open wounds	__ Current infections
__ Current flu or fever	__ Hernia	__ Current pregnancy
__ Osteoporosis	__ CVA / stroke	__ Seizures
__ Cancer	__ Fractures	__ Depression

Date and details of any conditions listed above, or about conditions not listed:

_____

_____

_____

Are you taking any of the following medications (yes / no)?

Anti-inflammatory _____

Pain reducer _____

Who is your Primary Care Physician?

Name _____ Phone # _____

Patient / Parent / Guardian signature _____ Date _____

Therapist's initials after review of information _____ Date _____