Patient Medical History

Rec Center Physical Therapy
A Fitness, Sports & Wellness Center

Last Name _____ First Name _____ Date _____

1) Have you received **PHYSICAL THERAPY** within this calendar year? ☐YES ☐NO
   If yes, how many visits? _____

2) Have you ever received physical therapy for this issue before? ☐YES ☐NO

3) Are you currently receiving Home Health/Nursing/other Therapy Services or have you received Home Health/Nursing/other Therapy Services within the past 30 days? ☐YES ☐NO
   If yes, where? _____

4) Are you currently receiving treatment from any other health care professional for this problem (not including the provider who referred you)? ☐YES ☐NO If yes, who? _____

5) Are you a Rockwell Collins Recreation Center member? ☐YES ☐NO

6) Do you have a past or present medical history of the following?

☐ Cancer	☐ Arthritis	☐ Osteoporosis	☐ High Blood Pressure	☐ Diabetes
☐ Heart Disease	☐ Asthma	☐ Kidney Disease	☐ Circulation Problems	☐ Pacemaker
☐ Epilepsy/Seizures	☐ Fractures	☐ Metal Implants	☐ Elevated Cholesterol	☐ Other _____

7) Please list any prior surgeries and dates: _____

8) Please list any ALLERGIES to Medications, LATEX, Food, Chemicals, or Other: _____

_____

Please list all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements

Name	Dosage	Frequency	What is it for?

(Please write additional medications on additional paper or have office copy card)