

CONFIDENTIAL MEDICAL HISTORY

Your answers on this form will help your therapist better understand your medical concerns and conditions. **Thank You**

NAME: _____

DATE: _____

DOB : _____
 WGT: _____

AGE: _____

SEX: _____

HGT: _____

HOW WOULD YOU RATE YOUR GENERAL HEALTH? Excellent Good Fair Poor

MAIN REASON FOR TODAY'S VISIT:

WHAT BODY PART IS INVOLVED:

ALLERGIES:

CURRENT MEDICATIONS, DOSAGE AND FREQUENCY:

SURGERIES AND DATES:

PREVIOUS ORTHOPEDIC INJURIES AND

Please check all that apply and give date of onset:

<input type="checkbox"/>	ALCOHOLISM	<input type="checkbox"/>	HEART DISEASE/ATTACK	<input type="checkbox"/>	SEIZURE/EPILEPSY
<input type="checkbox"/>	ASTHMA/ALLERGIES	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	SUBSTANCE ABUSE
<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	THYROID DISORDER
<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	MENTAL ILLNESS	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	HEADACHES	<input type="checkbox"/>	PULMONARY DISEASE	<input type="checkbox"/>	ULCERS
<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	SMOKING	<input type="checkbox"/>	
<input type="checkbox"/>	HIGH CHOLESTEROL	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	

SIGNATURE _____
DATE _____

PARENT/GARDIAN _____
DATE _____

THERAPIST/TRAINER _____
DATE _____