Medical History

DATE ____ / ____ / ____

LAST NAME _____ FIRST NAME _____

IN MOTION PHYSICAL THERAPY
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To provide you with the highest level of care in the safest and most appropriate fashion possible, we would like you to assist us by filling in the following information. Your medical information is confidential and will be used strictly by following HIPAA guidelines.

Please check the box if you have been diagnosed with any of the following:

- ☐ High Blood Pressure (Hypertension)
- ☐ Diabetes
- ☐ HIV / Hepatitis
- ☐ Pulmonary Disorder
- ☐ Organ Transplant
- ☐ Joint Replacement
- ☐ Other heart conditions not listed
- ☐ Current infection
- ☐ Recent falls
- ☐ Recent fracture
- ☐ **PACEMAKER**
- ☐ CVA / Stroke
- ☐ Heart Attack (MI)
- ☐ Headaches
- ☐ Neurological Disorder
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Blood Clots (DVT)
- ☐ Osteoporosis
- ☐ Seizures

Do you smoke? *(Circle)* Yes No

If female, are you currently pregnant? *(Circle)* Yes No

Blood Pressure: ____ / ____ **Height (In):** _____ **Weight (lbs):** _____

Please list any current, prescribed medications: _____

_____

_____

Please check tests performed for *conditions checked above only*:

☐ X-Ray ☐ MRI ☐ EMG ☐ CT ☐ Blood Work ☐ Bone Scan

☐ Other: _____

Please check if you have any of the following symptoms currently:

☐ Numbness ☐ Pins-and-needles sensation ☐ Pain that wakes you

☐ Recent unexplained weight loss ☐ Current Fever

_____ ____ / ____ / ____

SIGNATURE OF PATIENT OR GUARDIAN DATE