DYNAMIC PHYSICAL THERAPY

New Patient Information

PATIENT MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY TO YOUR CURRENT INJURY* If any apply, please ask front desk for appropriate forms to avoid incurring 100% of billed charges directly to you personally. _____ **(Initials)**

_____Auto Accident _____Employment Related _____Legal Representation

PLEASE MARK YES OR NO IF YOU HAVE HAD:

YES/NO Heart Surgery/Attack/Disease

YES/NO Stroke

YES/NO Cancer

YES/NO Epilepsy/Seizures

YES/NO Diabetes (Type I/Type II)

YES/NO High Blood Pressure

YES/NO Angina

YES/NO Whiplash

YES/NO Falls

PLEASE INDICATE IF YOU HAVE RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS:

YES/NO Blurred/double vision

YES/NO Change in bowel/ bladder habits

YES/NO Constant Pain

YES/NO Dizziness

YES/NO Tingling, numbness/loss of feeling

YES/NO Muscular pain at rest

YES/NO Unusual fatigue

YES/NO Unusual weakness

YES/NO Unusual skin coloration

YES/NO Unexplained weight loss

OTHER:

____ Alcohol abuse problems
____ Allergies
____ Arthritis
____ Back/Neck Injuries
____ Balance problems
____ Circulatory Problems
____ Dislocation of Joints
____ Emotional/Nervous problems
____ Fractures (broken bones)
____ Gastrointestinal problems
____ Gout
____ Kidney Disease
____ Lung Disease
____ Osteoporosis
____ Strains/Sprains
____ TMJ/ Jaw injuries
____ Headaches
____ Shortness of breath
____ Hoarseness
____ Muscular pain with exertion
____ Tremors
____ Pain with coughing/sneezing
____ Difficulty sleeping

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS

_____ DATE: _____

_____ DATE: _____

DO YOU SMOKE? YES / NO. If yes, how many per day? **ARE YOU PREGNANT**? YES / NO

ARE YOU ALLERGIC TO ANY MEDICATION? YES / NO. IF YES, LIST HERE:_____

CURRENT MEDICATIONS YOU ARE TAKING:

_____

_____

I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONAIRE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ ***Date:***_____

Treating Therapist's Signature _____ ***Date:***_____

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