PHYSICAL THERAPY
HISTORY INTAKE

Please answer the following questions regarding your past medical history

HAVE YOU HAD THE FOLLOWING?

Heart problems, pacemaker or any history of heart procedures? Yes ☐ No ☐
Explain : _____

High blood pressure? Yes ☐ No ☐
Explain: _____

Diabetes? Yes ☐ No ☐
Explain: _____

Cancer? Yes ☐ No ☐
Explain: _____

Blood/circulatory problems (deep venous thrombosis or thrombophlebitis,etc)? Yes ☐ No ☐
Explain: _____

Breathing problems (asthma, bronchitis, etc)? Yes ☐ No ☐
Explain: _____

Any skin problems/sensitivity (rash, irritation, etc) Yes ☐ No ☐
Explain: _____

Any other preexisting conditions? Yes ☐ No ☐
Explain: _____

Are you presently taking any medications? Yes ☐ No ☐
Explain: _____

Any history of previous injuries/accidents/surgeries? Yes ☐ No ☐
Explain: _____

Muscle/ joint problems? Yes ☐ No ☐
Explain: _____

Are you pregnant? Yes ☐ No ☐
Explain: _____

Any allergies? Yes ☐ No ☐
Explain: _____

Have you previously had physical therapy? Yes ☐ No ☐
Reason: _____
Location: _____

Patient Signature: _____ Date: _____