Core Physical Therapy
Medical History
MEDICAL INFORMATION

First Name _____ Last Name _____ Today's Date _____

Are you taking any of the following medications?

☐Other(s) ☐Stimulants ☐Insulin ☐Blood Thinners ☐Muscle relaxers
☐Pain medication (including over the counter) ☐Nerve pills ☐Steroids

Please list any medications you are taking: (prescriptions, injections, skin patches, over the counter)

_____

Please list any allergies you may have:

_____

Have you RECENTLY noted any of the following (check all that apply)?

☐I don't have any of these problems ☐Numbness or Tingling ☐Constipation
☐Fever/Chills/Sweats ☐Muscle weakness ☐Diarrhea Nausea/Vomiting
☐Dizziness/Lightheaded ☐Shortness of breath ☐Weight loss/gain
☐Heartburn/Indigestion ☐Fainting ☐Balance problems ☐Difficulty swallowing
☐Cough ☐Changes in bowel function ☐Changes in bladder function ☐Headaches
☐Fatigue

During the past month have you ever been feeling down, depressed, or hopeless?
☐No ☐Yes

During the past month have you been bothered by having little interest or pleasure in doing things?
☐No ☐Yes

Is this something with which you would like help?
☐No ☐Yes, but not today ☐Yes
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?
☐No ☐Yes

Do you have a history of any of the following diseases, medical conditions or procedures?

☐Hepatitis ☐Alcohol/Drug Abuse ☐Artificial Valves ☐Mitral Valve Prolapse
☐Congenital Heart Defect ☐Shingles ☐Eye problem/infection
☐Frequent Neck Pain ☐Diabetes ☐Anemia ☐High/Low Blood Pressure
☐Psychiatric Problems ☐Rheumatic Fever ☐Severe/Frequent Headaches
☐Ulcers/Colitisemia ☐Fainting/Seizures/Epilepsy ☐Sinus Problems
☐Emphysema/Asthma ☐Tuberculosis ☐Difficulty Breathing
☐Chemotherapy ☐Lower Back Problems ☐Artificial Bones/Joints/lmplants ☐Arthritis
☐Kidney Problems/lnfection ☐Depression ☐Blood clots ☐Pneumonia
☐Bone or joint infection ☐Rheumatoid arthritis ☐Multiple sclerosis
☐Osteoporosis ☐Circulation problems ☐Other arthritic conditions
☐Bladder/urinary tract infection ☐Pelvic inflammatory disease ☐Lung Problems
☐HIV+ / AIDS / ARC ☐Heart Attack ☐Stroke ☐Heart Surgery ☐Liver problems
☐Thyroid Problems ☐Glaucoma ☐Chest Pain/Angina ☐Pacemaker ☐Cancer
☐POTS ☐Hypermobility/EDS ☐Anxiety

Please list any other serious medical conditions you have, not listed above:

_____

List any surgeries you have had where any incisions were made, including joint replacements, organ removals/alterations, cancer removals, biopsies (with year)

_____

List any previous fractures (with year):

_____

Are you under doctor ordered work restriction? if so, explain.

_____

Do you take Supplements or Vitamins? ☐No ☐Yes

Do you exercise? ☐No ☐Yes
Please list your form of exercise and frequency

_____

Do you smoke? ☐No ☐Yes

Are you pregnant? ☐No ☐Yes

If yes, how long have you been pregnant? _____

Are you wearing: ☐Arch supports ☐Inner soles ☐Heel lifts