

HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING

Orthopedic Therapy and Sports Conditioning Center

Patient Name: _____

Medical History

Allergies	Y	N
Anemia	Y	N
Anxiety	Y	N
Arthritis	Y	N
Asthma	Y	N
Cancer	Y	N
Cardiac Conditions	Y	N
Cardiac Pacemaker	Y	N
Chemical Dependency	Y	N
Circulation problems	Y	N
Currently Pregnant	Y	N

Depression	Y	N
Diabetes	Y	N
Dizzy Spells	Y	N
Emphysema/Bronchitis	Y	N
Fractures	Y	N
Gallbladder Problems	Y	N
Hepatitis	Y	N
High blood pressure	Y	N
Incontinence	Y	N
Kidney Problems	Y	N
Metal Implants	Y	N

Multiple Sclerosis	Y	N
Osteoporosis	Y	N
Parkinsons	Y	N
Rheumatoid Arthritis	Y	N
Seizures	Y	N
Speech Problems	Y	N
Strokes	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N
Vision Problems	Y	N

Describe Any Other Conditions or Explain Above Conditions: _____

Fall History

Is this injury a result of a fall in the past year? **Y / N**

Have you had two or more falls in the last year? **Y / N**

Surgical History

Check here if a surgical history was provided

Surgery Type: _____ When (MM/YYYY): ____/____

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Current Medications

Check here if a medication list was provided

Drug: _____ Dosage: _____ Reason for Taking: _____

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Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Job Description/Social Activites (physical tasks, amount of sitting, lifting, computer work, etc.): _____

What are your goals for your course of physical therapy? _____

At the present time, would you say your health is excellent, very good, fair, or poor? _____

Patient Signature: _____

Date: _____

Therapist Name (Print and Sign): _____

