Simply Results
PHYSICAL THERAPY
Keeping you moving…getting you better!

Medical History page 1 of 2 Date:_____

Patient Name: _____Date of Birth: _____/____/_____

Allergies	yes	no	Dizzy spells	yes	no	MRSA	yes	no
Anemia	yes	no	Emphysema/ Bronchitis	yes	no	Multiple Sclerosis	yes	no
Anxiety	yes	no	Fibromyalgia	yes	no	Muscular Disease	yes	no
Arthritis	yes	no	Fractures	yes	no	Osteoporosis	yes	no
Asthma	yes	no	Gallbladder Problems	yes	no	Parkinson's Disease	yes	no
Autoimmune Disorder	yes	no	Headaches	yes	no	Rheumatoid Arthritis	yes	no
Cancer	yes	no	Hearing Impairment	yes	no	Seizures	yes	no
Cardiac Conditions	yes	no	Hepatitis	yes	no	Smoking	yes	no
Cardiac Pacemaker	yes	no	High Cholesterol	yes	no	Speech Problems	yes	no
Chemical Dependency	yes	no	High Blood Pressure	yes	no	Strokes	yes	no
Circulation Problems	yes	no	HIV/AIDS	yes	no	Thyroid Disease	yes	no
Currently Pregnant	yes	no	Incontinence	yes	no	Tuberculosis	yes	no
Depression	yes	no	Kidney Problems	yes	no	Vision Problems	yes	no
Diabetes	yes	no	Metal Implants	yes	no	Dementia	yes	no

Women:
Number of Pregnancies:
Number of Vaginal Births:
Any episiotomies or tearing?:

Men:
Prostate cancer?:

Describe any other Conditions or Precautions:

Falls History: Injury as a result of a fall in the past year? YES NO Date of Fall: _____

Two or more falls in the last year? YES NO Date(s) of Falls: _____

Please list any Home Falls Hazards you or others have identified:

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Patient Name:_____ **Date**_____
Medical History page 2 of 2

You may submit a separate list, if you have one, for us to enter, but we are required to have the following information:

Surgical History:

Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**
Body region:	**Surgery Type:**	**Month/Day/Year:**

Please bring along a list of your current medications, instead of re-writing them here. We are required to have the following information:

Current Medications:

Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**
Drug:	**Dosage:**	**Frequency:**	**Route:**	**Reason for taking:**

Please enter your height (_____ feet, _____ inches), as well as your current weight (_____ pounds.) Thank you.

In our office, we can take your Vitals: Blood Pressure_____ Heart Rate_____ O2 sats:_____

PLEASE share in your words why you're here, and your goals for during and after the physical therapy process.

Thank you for your time.

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