PEAK PHYSICAL THERAPY AND WELLNESS

PATIENT HISTORY FORM

Name_____ **Sex** _____**Date of Birth**_____

Height _____ **Weight** _____

Please complete all required information. Use reverse side, if needed, for additional space

1. Do you or have you ever had?

High Blood Pressure	No ☐ Yes ☐	Breathing Problems	No ☐ Yes ☐
Heart Trouble	No ☐ Yes ☐	Fracture	No ☐ Yes ☐
Circulation Problems	No ☐ Yes ☐	Stroke	No ☐ Yes ☐
Seizures	No ☐ Yes ☐	Arthritis	No ☐ Yes ☐
Dizzy Spells	No ☐ Yes ☐	Diabetes	No ☐ Yes ☐
Claustrophobia	No ☐ Yes ☐		
Pneumonia	No ☐ Yes ☐	Depression	No ☐ Yes ☐
Chest Pain	No ☐ Yes ☐	Pain at Night	No ☐ Yes ☐
Blood Clots	No ☐ Yes ☐	Leg swelling	No ☐ Yes ☐
Osteoporosis	No ☐ Yes ☐	Osteopenia	No ☐ Yes ☐
Recent falls	No ☐ Yes ☐	(*In the last year)	
Other Illness	No ☐ Yes ☐	_____	

2. Have you ever had Surgery? No ☐ Yes ☐ If yes, give Date(s), Operation(s), and Outcome(s)

_____

3. Do you have any metal anywhere in your body (other than your teeth)? No ☐ Yes ☐
4. Do you have a Cardiac (heart) Pacemaker? No ☐ Yes ☐
5. (For Women Only) Are you now pregnant? No ☐ Yes ☐ Date of last period_____
6. List medical tests done for this condition_____

_____

7. List any Allergies you have_____

_____

8. Have you ever had Physical Therapy treatments before? No ☐ Yes ☐
   If Yes, indicate Where, When and for What problem_____

_____

9. Describe briefly the history of your present accident or illness_____

_____

10. Please list prior accidents or work injuries_____

_____

11. Work Status ☐Regular Duty ☐ Light Duty ☐Off Duty

12. Any recent hospitalizations?_____

13. Do you live alone? _____Do you rely on anyone for assistance during your day? _____

14. How many stairs to enter your home?_____How many stairs inside your home?_____

15. Are there handrails with the stairs?_____

16. What floor is your bathroom/shower on?_____Bedroom?_____

18. Please list all of your medications with dosages: (Or supply a medication list)

MEDICATION	**DOSAGE**

For additional space, please write on the reverse side of this page.

Date

Signature

If not Patient, indicate relationship (Parent, Guardian, Other)