ridgefield physical therapy

Patient Name: _____

MEDICAL HISTORY FORM

PLEASE PUT AN **X** IF YOU HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING:

☐ STROKE	☐ SURGERY	☐ CURRENTLY PREGNANT	☐ VERTIGO
☐ CARDIAC PROBLEMS	☐ CANCER	☐ ALLERGY TO MEDICATION	☐ FRACTURES
☐HIGH BLOOD PRESSURE	☐ DIABETES	☐ALLERGY TO LATEX	☐ SURGERY:
☐ PACEMAKER	☐SEIZURES	☐ AIDS/HIV	_____
☐ASTHMA	☐ METAL IMPLANTS	☐ SMOKE CIGARETTES	☐ OTHER:
☐ ARTHRITIS	☐ DIFFICULTY WALKING	☐ OSTEOPOROSIS	_____

Please answer the following:

Date of injury: _____

Did this injury happen at work? ☐ yes ☐ no

Did this injury happen in a car accident? ☐ yes ☐ no What state? _____

Have you received prior treatment for this problem? ☐ yes ☐ no

If yes, when, what and where? (please include home healthcare)_____

Height _____ Weight _____

Please list any medications you are currently taking:

Medication:	Dosage:	Route:
_____	_____	__Oral/__Other_____
_____	_____	__Oral/__Other_____
_____	_____	__Oral/__Other_____
_____	_____	__Oral/__Other_____
_____	_____	__Oral/__Other_____
_____	_____	__Oral/__Other_____

When is your next scheduled appointment with the doctor who referred you to physical therapy? _____

Please give at least 24 hours notice when cancelling or changing an appointment. There will be a $30 fee for all no shows and late cancellations. Your therapist reserves the right to discontinue your treatment in the event of frequent cancellations and/or no shows.

PATIENT'S SIGNATURE _____ DATE: _____