AllCare Physical Therapy
Medical History Form
PLEASE PRINT

Patient Name: _____ **Date:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

IS THIS INJURY/CONDITION A RESULT OF AN AUTO ACCIDENT, WORK RELATED, OR OTHER LIABILITY? _____
IF AN INJURY, HOW DID IT OCCUR? _____
WHAT BODY PART ARE WE TREATING? _____
WHEN IS YOUR NEXT FOLLOWUP APPOINTMENT WITH YOUR DOCTOR? _____
HAVE YOU RECENTLY BEEN HOSPITALIZED? _____ IF YES, WHEN? _____
ARE YOU PRESENTLY WORKING? _____
***ARE YOU RECEIVING OR HAVE YOU RECENTLY RECEIVED HOME HEALTH SERVICES? Y N**
***ARE YOU RECEIVING OR HAVE YOU RECENTLY RECEIVED OTHER THERAPY SERVICES? Y N**
IF YES, WHAT WAS DONE AND WHAT WAS THE OUTCOME & WHEN WERE YOU DISCHARGED?
_____
_____

DESCRIBE YOUR GENERAL HEALTH: __Excellent __Good __ Fair __ Poor
ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITION? **Y N**
IF YES, PLEASE PROVIDE A BRIEF DESCRIPTION. _____
DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? Check all that apply:

ANEMIA	DEPRESSION	HEPATITIS/HIV	PACEMAKER
ARTHRITIS	DIABETES	HIGH BLOOD PRESSURE	RESPIRATORY PROBLEMS
ASTHMA	DIZZINESS/FAINTING	KIDNEY PROBLEMS	SEIZURES
CANCER	FRACTURES	LOW BLOOD PRESSURE	SUBSTANCE ABUSE
CARDIAC	HEADACHES	METAL IMPLANTS	THYROID

WOMEN, ARE YOU CURRENTLY PREGNANT? **Y N**

DO YOU USE TOBACCO PRODUCTS? **Y N** IF YES, HOW MUCH PER DAY?_____
DO YOU CONSUME ALCOHOL? **Y N** IF YES, HOW MUCH PER DAY? _____

PLEASE LIST YOUR CURRENT MEDICATIONS OR PROVIDE US WITH A LIST. _____
_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE ABOVE QUESTIONS HONESTLY:

SIGNATURE: _____

REVIEWED BY: _____ **P.T.**