Capitol Physical Therapy

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Medical History

Patient Name: ____ Date: ____________________________

Describe any previous treatment for the condition we are seeing you for today. ___________________________

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Do you have a previous injury or condition that may affect your treatment? ______________________________

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Are you experiencing any of the following? **(Circle)**

Weight Change / Fever / Chills / Night Sweats   Pregnancy   Numbness/Tingling
Falls / Loss of Balance   Loss of Consciousness / Fainting

Please list any medications you are currently taking: ____

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Do you exercise?	Yes / No	Do you wear glasses/contacts?	Yes / No	Do you use alcohol?	Yes / No
Do you smoke?	Yes / No	Are you currently dieting?	Yes / No	Are you hard of hearing?	Yes / No

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Please mark **(X)** if you have or have ever had any of the following?

_____ Frequent Headaches
_____ Asthma / Lung Disease
_____ Sprains / Strains
_____ Nervous Disorders
_____ Broken Bones
_____ Rheumatoid Arthritis
_____ Surgeries
_____ Kidney Problems
_____ Shortness of Breath
_____ Circulation Problems
_____ Other allergies
_____ Paralysis
_____ Allergies to heat or ice
_____ Anemia
_____ Dizziness
_____ Diabetes
_____ Respiratory Problems
_____ Cancer
_____ Blood Pressure Problems
_____ Seizures

Please explain and give approximate dates for any items indicated above:

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Please diagram your symptoms on the body chart below:

Numbness/tingling: XXX   Burning: OOO   Sharp Pain: ///   Aching: ===