PAR PHYSICAL THERAPY
MEDICAL HISTORY

Patient Name: _____ DOB: _____

Primary Care Physician: _____

Please circle any that apply to your medical history:

High Blood Pressure	Heart Disease	Numbness	Pacemaker
Shortness of Breath	Female Issues	Weakness	Pregnant
Night Pain	Stroke	Diabetes	Dizziness
Irregular Heart Rate	Fatigue	Osteoporosis	Headaches

List any other medical history: _____

Have you fallen in the past year? **YES** – **NO** Height: _____ Weight: _____

Medications: _____

Surgeries: _____

General Health: (circle one) Poor Fair Good Excellent

In the past 3 months have you experienced any significant changes in health? (physical or mental):

_____

CURRENT COMPLAINT

Current Complaint: _____ Start Date: _____

How did it start? _____ Previous Therapy: **YES** – **NO**

Does your pain radiate? **YES** – **NO** Where: _____ Pain Level (0-10): _____

Surgical Date if Applicable: _____ Surgeon: _____

Restrictions: **YES** – **NO** _____ Diagnostics Tests: _____

Signature: _____ Date: _____