BeneFIT Physical Therapy

Medical History Form

Patient: _____ SS#:_____-_____-_____

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE/HAVE HAD:

1. High Blood Pressure	yes	no	25. Thyroid Problems	yes	no
2. Chest Pains/Angina/Heart Attack	yes	no	26. Polio/Muscle Disease	yes	no
3. High Cholesterol	yes	no	27. Seizures	yes	no
4. Pacemaker	yes	no	28. Chronic/Migraine Headaches	yes	no
5. Shortness of Breath	yes	no	29. TMJ Disorders	yes	no
6. History of Smoking	yes	no	30. Chills/Fevers Sweats	yes	no
7. Lung Problems	yes	no	31. Swelling of Extremities	yes	no
8. Emphysema/Asthma	yes	no	32. Sleep Disorders	yes	no
9. Bleeding/Bruising	yes	no	33. Depression	yes	no
10. Anemia	yes	no	34. Fibromyalgia	yes	no
11. Diabetes	yes	no	35. Chronic Fatigue Syndrome	yes	no
12. Hypoglycemia	yes	no	36. Lyme's Disease	yes	no
13. Lightheadedness/Dizziness	yes	no	37. Cancer/Tumors/Growths	yes	no
14. Blood Disorders	yes	no	38. Are you pregnant?	yes	no
15. Concussion	yes	no	39. Gynecological Disorders	yes	no
16. Fainting Disorders	yes	no	40. Bladder Incontinence	yes	no
17. Anxiety/Panic Attacks	yes	no	41. Bowel Incontinence	yes	no
18. Arthritis/Joint Pain	yes	no	42. Diarrhea/Nausea/Vomiting	yes	no
19. Artificial Joints	yes	no	43. Unexplained Weight Loss >10 lbs./last30days	yes	no
20. Kidney Disease/Stones	yes	no	44. UNDER 18 ONLY:		
21. Hepatitis	yes	no	Immunizations Current	yes	no
22. Spinal Cord Injury	yes	no			
23. Traumatic Brain Injury	yes	no			
24. Fractures:	yes	no			

Date: _____Area:_____

45. Rate your Pain 0-10

(none) 0	1	2	3	4	5	6	7	8	9	10 (unbearable)

CURRENT MEDICATIONS: _____

_____

ALLERGIES:

A. To Medications:_____

B. To Other Substances:_____

SURGERY(S) Include dates:_____

X-RAYS, MRI, CAT SCAN (Include Area & Dates):_____

What Are Your Treatment Goals? _____

Patient Signature_____Date: _____

Relationship if other than patient/ Parent/ Guardian if Minor _____

This information will be used as a guide in your treatment plan. If you need any medical follow-up, please contact your physician.