

DATE _____



PERSONAL HEALTH/INJURY HISTORY

Please complete form for each new diagnosis

DIAGNOSIS: _____

HISTORY OF INJURY:

LOCATED WHERE? _____

FOR HOW LONG? _____

PREVIOUS PHYSICAL THERAPY

FOR WHAT? _____

FOR HOW LONG? _____

MEDICAL HISTORY

SURGERY? _____

ANY RELEVANT MEDICAL CONDITIONS? _____

MEDICATIONS

NAME _____

DOSAGE _____

TAKEN FOR WHAT? _____

FAMILY MEDICAL HISTORY

HYPERTENSION

HEART DISEASE

ANY CHRONIC DEBLITATING DISEASE

DIABETES

ARTHRITIS
