Jersey PHYSICAL THERAPY Of South Brunswick

Medical History

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Claustrophobia	☐	☐	Seizures	☐	☐
Cardiac Condition	☐	☐	Kidney Problems	☐	☐	Dizzy Spells	☐	☐
Heart Attack	☐	☐	Liver Problems	☐	☐	Diabetes	☐	☐
Pacemaker	☐	☐	Cancer	☐	☐	Allergies	☐	☐
Circulation Problems	☐	☐	Vision Problems	☐	☐	Fractures	☐	☐
Arthritis	☐	☐	Speech Problems	☐	☐	Strokes	☐	☐
Osteoporosis	☐	☐	Sensitivity to Heat	☐	☐			
Nervous Disorders	☐	☐	Sensitivity to Cold	☐	☐			
Asthma	☐	☐	Metal Implants	☐	☐	Are you pregnant?	☐	☐

Have you suffered from any illnesses not listed above? ☐ Yes ☐ No If yes, please explain:

_____

_____

Have you ever had surgery including this current condition? ☐ Yes ☐ No
If yes, please list the type of surgery and the year it was done:

Type:_____ Date: _____ Type: _____ Date: _____
Type: _____ Date: _____ Type: _____ Date: _____

Have you had therapy for your current condition? ☐ Yes ☐ No If yes, please list:
Location: _____ Dates: _____ # of Visits: _____

Please list any medications, or herbal supplements you are currently taking:

Type: _____ Dosage: _____ Type: _____ Dosage: _____

Type: _____ Dosage: _____ Type: _____ Dosage: _____

Type: _____ Dosage: _____ Type: _____ Dosage: _____

What body part are we treating? _____Date of Onset_____/_____/_____

Are we treating you as a result of a fall? ☐ Yes ☐ No
Have you fallen more then twice in the last year? ☐ Yes ☐ No

Describe the history of your present condition. Please provide all important details:

_____

_____

What are your goals or expectations of therapy?

_____

Patient: _____ Date of Birth: _____/_____/_____
Signature: _____ Today's Date: _____/_____/_____