



SPORTS THERAPY AND REHABILITATION, INC

MEDICAL HISTORY AND INFORMATION

Name: _____ Occupation: _____ Age: _____

Are you latex sensitive? YES NO

Do you have any other allergies? YES NO (List) _____

Do you smoke cigarettes? YES NO

FOR WOMEN: Are you currently pregnant or do you think you might be pregnant? YES NO

Are you under the care of any of the following? (Please Check):

- | | | | | |
|---|---------------------------------------|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Orthopedist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Dentist | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Psychiatrist/Psychologist | |

Have you ever been diagnosed with the any of the following conditions?

- | | | |
|---|---|---|
| YES <input type="checkbox"/> NO <input type="checkbox"/> Cancer | YES <input type="checkbox"/> NO <input type="checkbox"/> Heart Problems | YES <input type="checkbox"/> NO <input type="checkbox"/> High Blood Pressure |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Asthma | YES <input type="checkbox"/> NO <input type="checkbox"/> Diabetes | YES <input type="checkbox"/> NO <input type="checkbox"/> Circulation Problems |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Hepatitis | YES <input type="checkbox"/> NO <input type="checkbox"/> Thyroid Problems | YES <input type="checkbox"/> NO <input type="checkbox"/> Emphysema/Bronchitis |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Stroke | YES <input type="checkbox"/> NO <input type="checkbox"/> Multiple Sclerosis | YES <input type="checkbox"/> NO <input type="checkbox"/> Rheumatoid Arthritis |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Tuberculosis | YES <input type="checkbox"/> NO <input type="checkbox"/> Kidney Disease | YES <input type="checkbox"/> NO <input type="checkbox"/> Other Arthritic Problems |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Anemia | YES <input type="checkbox"/> NO <input type="checkbox"/> Pacemaker | YES <input type="checkbox"/> NO <input type="checkbox"/> Epilepsy/Seizures |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Dizziness | YES <input type="checkbox"/> NO <input type="checkbox"/> Headaches | YES <input type="checkbox"/> NO <input type="checkbox"/> Depression/Anxiety |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Herpes | YES <input type="checkbox"/> NO <input type="checkbox"/> HIV/AIDS | YES <input type="checkbox"/> NO <input type="checkbox"/> Osteoporosis |

Please list any surgeries and/or hospitalizations along with the date and reasons for each: _____

Please list any significant injuries for which you have been treated (fractures, sprains, dislocations, etc.) with the approximate date of injury: _____

Please list any **OVER THE COUNTER MEDICATIONS** you have taken THIS WEEK

1. _____ 2. _____ 3. _____

Please list any **PRESCRIPTION MEDICATIONS** you are CURRENTLY TAKING

1. _____ 2. _____ 3. _____

Have you recently noticed?

- | | | |
|---|--|--|
| YES <input type="checkbox"/> NO <input type="checkbox"/> Weight Loss/Gain | YES <input type="checkbox"/> NO <input type="checkbox"/> Weakness | YES <input type="checkbox"/> NO <input type="checkbox"/> Fatigue |
| YES <input type="checkbox"/> NO <input type="checkbox"/> Fevers/Chills/Sweats | YES <input type="checkbox"/> NO <input type="checkbox"/> Nausea/Vomiting | YES <input type="checkbox"/> NO <input type="checkbox"/> Numbness/Tingling |

Please describe your chief problem: _____

Patient Signature: _____

Therapist Signature: _____

Date: _____

Date: _____