PERFORMANCE PT
physical therapy + sports training

Medical History Form

NAME:_____

Family Physician: _____ Current Sport: _____

Do you have any current or previous medical conditions that might limit your training? YES NO

If YES, please explain:

_____

_____

Are you currently taking any prescription or non-prescription medications? YES NO

Anti-inflammatories	_____	List other medications
Pain medications	_____	_____
Muscle relaxors	_____	_____

Have you had any of the following medical or rehabilitative services for any injury/episode?

	YES	NO		YES	NO
Physical therapy	____	____	General practitioner	____	____
Occupational therapy	____	____	Orthopedist	____	____
Emergency room care	____	____	Neurologist	____	____
EMG/NCV	____	____	X-rays	____	____
Myelogram	____	____	MRI	____	____
Chiropractor	____	____	CT Scan	____	____
Massage therapy	____	____	Podiatrist	____	____

Do you now have, or have you ever had, any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Severe or Frequent Headaches	____	____
Shortness of Breath/Chest pain	____	____	Vision or Hearing Difficulty	____	____
Coronary Heart Disease or Angina	____	____	Numbness or Tingling	____	____
Pacemaker	____	____	Dizziness or Fainting	____	____
High Blood Pressure	____	____	Weakness	____	____
Heart Attack/Heart Surgery	____	____	Weight Loss/Energy Loss	____	____
Blood Clot/Emboli	____	____	Hernia	____	____
Stroke/TIA	____	____	Epilepsy/Seizures	____	____
Allergies	____	____	Thyroid trouble/Goiter	____	____
Any Pins or Metal Implants	____	____	Anemia	____	____
Joint replacement	____	____	Bowel or Bladder Problems	____	____
Diabetes	____	____	Neck Injury / Surgery	____	____
Infectious Diseases	____	____	Shoulder Injury / Surgery	____	____
Cancer/Chemotherapy/Radiation	____	____	Elbow / Hand Injury or Surgery	____	____
Arthritis / Swollen Joints	____	____	Back Injury or Surgery	____	____
Osteoporosis	____	____	Knee Injury or Surgery	____	____
Sleeping problems or difficulties	____	____	Leg/Ankle/Foot Injury / Surgery	____	____
Emotional / Psychological Problems	____	____	Do you smoke?	____	____
Are you pregnant?	____	____	Satisfied with your weight?	____	____

What are your expectations/goals while in this program?_____

Patient / Guardian Signature: _____ Date: _____