MOUNT HOPE PHYSICAL AND AQUATIC THERAPY

MEDICAL HISTORY

Name: _____ **DATE:** _____

Are you currently taking any prescription or non-prescription medication? Yes_____ No_____
(If yes please list them on form provided or give front desk staff a copy your list.)

Are you allergic to any medications? Yes___ No ___
If yes, please describe_____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	Yes	No		Yes	No
Chiropractor			CT Scan		
EMG/NCV			General Practitioner		
Massage Therapy			MRI		
Myelogram			Neurologist		
Occupational Therapy			Orthopedist		
Physical Therapy			Podiatrist		
Emergency Room			X-Ray		

Other:_____

Do you now have or have you ever had ANY of the following?

	Yes	No		Yes	No
Asthma, bronchitis, COPD or emphysema, shortness of breath/chest pain			Severe or frequent headaches		
Coronary heart disease or angina			Vision or hearing difficulties		
Pacemaker/Defibrillator			Numbness or Tingling		
High blood pressure			Dizziness or Fainting		
Heart Attack or Heart Surgery			Bowel/Bladder Incontinence		
Stroke/TIA			Weakness		
Blood Clot/Emboli			Weight loss/energy loss		
Epilepsy/seizures			Hernia		
Thyroid Disease or goiter			Varicose Veins		
Anemia			Any pins or metal implants		
Infectious Diseases			Joint replacement surgery		
Diabetes			Neck injury/surgery		
Cancer or chemotherapy/radiation			Shoulder injury/surgery		
Arthritis			Elbow/hand injury/surgery		
Osteoporosis			Back injury/surgery		
Gout			Knee injury/surgery		
Sleeping problems/difficulties			Are you pregnant?		
Emotional/psychological problems			Do you use tobacco?		
Do you use Oxygen?			Open Wound		
Neuropathy			Colostomy bag		

Patient/Guardian Signature:_____