Harbor Physical Therapy & Wellness CLINIC

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Medical History Form

Name:_____ Date:_____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance.

MEDICAL HISTORY: (please check any condition you have a history of. Items not checked are understood to be negative.)

____ High Blood Pressure
____ Heart Problem
____ Abnormal Heart Rate
____ Pacemaker
____ Heart Palpitations
____ Angina
____ Shortness of Breath
____ Osteoporosis
____ Arthritis
____ Abnormal Bleeding
____ Asthma
____ Emphysema
____ Chronic Lung Problem
____ Chronic Heart Burn
____ History of Ulcers
____ High Cholesterol
____ Night Sweats
____ Dizziness
____ Bowel or Bladder Problems
____ Autoimmune disorder
____ Recent or sudden weight loss/gain
____ Thyroid problem (hyper or hypo)
____ Diabetes (medication dependent? Y N
____ Cancer/tumors (_____)
____ Seizures/Epilepsy
____ Chronic heartburn/Intestinal upset
____ Hearing problems

Other: _____

Do you have any metal implants?	YES	NO	Location:_____
Do you smoke?	YES	NO	How much per day?_____
Do you exercise regularly?	YES	NO	How often?_____
Do you have any known allergies?	YES	NO	Please list:
Are you allergic to latex?	YES	NO	
Are you pregnant or suspect pregnancy?	YES	NO	

SURGERIES: (Please list all surgeries, including date.)

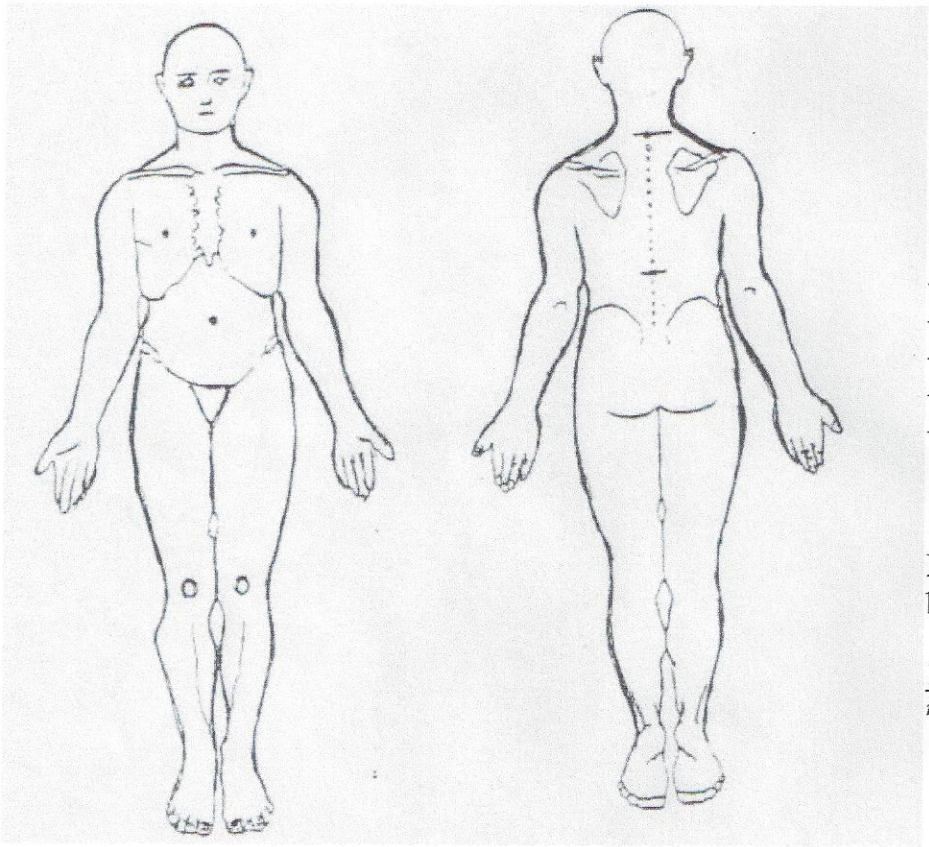
_____

_____

_____

Please complete backside

Please indicate the location of your pain:



Chief Complaint/Current Conditions:

_____

_____

_____

_____

_____

Please rate your pain on the scale below:

1 2 3 4 5 6 7 8 9 10

no pain *worst pain imaginable*

I beleive all information to be true and complete.

Patient printed name:_____

Patient signature:_____ Date:_____