FULL NAME _____ **Date of Birth** _____

MEDICAL PROBLEMS: (Please check only those that apply to you)

CARDIOVASCULAR
- □ **No Identified Problem**
- □ Hypertension(High BP)
- □ Hypotension (Low BP)
- □ Heart Attack
- □ Chest Pain/Angina
- □ Irregular Rhythm or Murmur
- □ Congestive Heart Failure
- □ Varicose Veins
- □ Pacemaker □ Defibrillator
- □ Circulation Problems
- □ Pain in Calves with Walking
- □ Blood Clots/Phlebitis
- □ Aneurysm
- □ Blood/Bleeding Disorder_____
- □ Other_____

METABOLIC
- □ **No Identified Problem**
- □ Diabetes
  - □ Insulin Dependent
  - □ Oral medications
  - □ Diet Controlled
- □ Blood Sugar □ High □ Low
- □ Hyperthyroid
- □ Hypothyroid
- □ Other_____

SOCIAL/PSYCHOLOGICAL
- □ **No Identified Problem**
- □ Alcohol Use_____Times a Week
- □ Tobacco Use_____Packs a Day
- □ Substance Abuse
- □ Depression
- □ Anxiety / □ Panic
- □ Claustrophobia
- □ ADD / □ ADHD
- □ History of Abuse
- □ Under care of a Psychiatrist
- □ Under care of a Psychologist
- □ Other_____

ORTHOPEDIC (include body part and date)
- □ **No Identified Problem**
- □ Joint Replacements
  - Type/Date_____
  - Type/Date_____
- □ Metal Implants: □ Plate □ Pins □ Rod
- □ Osteoporosis □ Osteopenia
- □ Amputation_____
- □ Fractures / Broken Bones_____
- □ Spinal Problems_____
- □ Osteoarthritis_____
- □ Sprain / □ Strain_____
- □ Gout
- □ Other_____

PULMONARY
- □ **No Identified Problem**
- □ Asthma / □ Bronchitis
- □ Emphysema / □ COPD
- □ Asbestosis / Mesothelioma
- □ Shortness of Breath
- □ Tuberculosis(TB)/ □ Exposure
- □ Pneumonia
- □ Snoring / □ Sleep Apnea
- □ Breathing Devices
- □ Dysphagia (Swallowing Problems)
- □ Other_____

GASTROINTESTINAL
- □ **No Identified Problem**
- □ Hepatitis □ A □ B □ C
- □ Gastrointestinal Ulcers
- □ Hiatal Hernia □ Reflux
- □ Unexplained Weight □ Loss □ Gain
- □ Anorexia □ Bulimia
- □ Gall Bladder Disease
- □ Nausea □ Vomiting
- □ Crohn's Disease □ Colitis
- □ Irritable Bowel Syndrome
- □ Diverticulitis
- □ Bowel Incontinence □ Leakage
- □ Constipation
- □ Other_____

NEUROLOGIC
- □ **No Identified Problem**
- □ Migraine
- □ Loss of Consciousness
- □ Balance Problems / Vertigo
- □ Fainting / Blackouts
- □ Parkinson's Disease
- □ ALS (Lou Gehrig's Disease)
- □ Rheumatic Fever
- □ Weakness in Arms or Legs
- □ Polio/Post-Polio Syndrome
- □ Epilepsy / Seizures
- □ Stroke(CVA) □ TIA
- □ Head Injury(TBI) □ Concussion
- □ Memory Loss □ Confusion
- □ Spinal Cord Injury
  - Level:_____
- □ Multiple Sclerosis(MS)
- □ Coordination Problems
- □ Dizziness
- □ Aphasia / □ Speech Problems
- □ Shunt Placement
- □ Hypoxia_____
- □ Other_____

GENITOURINARY
- □ **No Identified Problem**
- □ Kidney Stones
- □ GYN Disorder_____
- □ Blood in Urine
- □ Kidney Disease □ Failure □ Dialysis
- □ Urinary
  - □ Burning □ Urgency □ Frequency
- □ Bladder Incontinence □ Leakage
- □ Prostate Disorder
- □ Other_____

GENERAL MEDICAL
- □ **No Identified Problem**
- □ Glaucoma / □ Cataracts
- □ Vision Problems
- □ Glasses_____
- □ Hearing Deficit / □ Hearing Aide(s)
- □ Blood Disease □ Anemia
- □ Cancer
  - Type:_____
  - Location:_____
- □ Chronic Pain □ Night Pain
- □ Skin Problems_____
- □ Edema / Swelling
- □ Lymphedema
- □ Rheumatoid Arthritis
- □ Infectious Disease_____
- □ Zoster / Shingles □ Chicken Pox
- □ Sexually Transmitted Disease
- □ Pregnancy □ YES □ NO
- □ Other_____

PEDIATRIC / CHILDHOOD HEALTH HISTORY
Pediatric Patients ONLY

- □ **No Identified Problem**
- □ Intellectual Disability
- □ Down's Syndrome
- □ Autism Spectrum Disorder
- □ Behavior Concerns
- □ Developmental Concerns
- □ Cerebral Palsy
- □ Birth Complications
- □ Chromosomal Abnormalities
- □ ADD/ADHD
- □ PANS/PANDAS
- □ Other_____

IMMUNIZATIONS
Up To Date
□ YES □ NO

FULL NAME _____ **Date of Birth** _____

Chief Complaint/Reason for Therapy Visit:_____

_____

Allergies:_____ **Height:** _____**Weight:** _____

Diagnostic Tests Completed in the Past Year:_____

_____

Current / Past Hospitalizations (month/year)**:**_____

_____

_____

Current Past Surgeries (month/year)**:**_____

_____

_____

History of FALLS in past six months: □ **YES** □ **NO** If yes, when_____

List ALL Current medications or □ **List Attached**

Medication	Condition	Dosage	How Often

List ALL Current Vitamins, nutritional Supplements, Herbal Remedies, etc.:

Supplement	Condition	Dosage	How Often

What are Your Rehab Goals?_____

_____

Are you currently receiving or have you received any of the following services within the past year?

□ Physical Therapy □ Occupational Therapy □ Speech/Swallowing □ Home Care

□ **Patient** □ **Parent** □ **Legal Guardian Signature**_____ Date:_____