FITLIFE SINCE 2002

## Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with information regarding your health status found on this form. If you do not understand a question, leave the area blank and your therapist will assist you. Thank you!

Name:_____ Date:_____ Current FitLife Member? YES NO

| **Are you currently:** | **Have you ever had physical therapy for this condition?** |
|---|---|
| □ Working at your usual job with no restrictions<br>□ Working at your usual job with restrictions<br>□ Unable to work due to others medical reasons<br>□ Retired/Unemployed/Homemaker | Circle: YES NO |

**Are you seeing:** □ Medical Doctor □ Dentist □ Psychiatrist/Psychologist
□ Osteopath □ Physical therapist □ Chiropractor

If you have seen any of the above during the last three months, please describe reason

_____
_____
_____

**Have you EVER been diagnosed as having any of the following conditions:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes | No | Heart problems | Yes | No | Hearing loss/disorder | Yes | No | Circulation Problems |
| Yes | No | High blood pressure | Yes | No | Eye Disease | Yes | No | Osteoporosis |
| Yes | No | Stroke | Yes | No | Muscle disease/disorder | Yes | No | Cancer |
| Yes | No | Rheumatoid Arthritis | Yes | No | Multiple Sclerosis | | If yes, what kind:_____ | |
| Yes | No | Other Arthritic Problem | Yes | No | Diabetes | Yes | No | Past Pregnancy: |
| Yes | No | Epilepsy | Yes | No | Tuberculosis | | Delivery (please circle):vaginal cesarian | |
| Yes | No | Lung Disease | Yes | No | Hepatitis | Yes | No Currently Pregnant____months | |
| Yes | No | Emphysema/Bronchitis | Yes | No | Kidney Disease | Yes | No | Other:_____ |
| Yes | No | Asthma | Yes | No | Thyroid Problems | | | |
| Yes | No | Chemical Dependency | Yes | No | Depression | | | |

**Please list any surgeries or other conditions for which you have been hospitalized, including dates and reasons.**

**Date** **SURGERY** **REASON:**

_____
_____
_____

**Please describe any injuries for which you have been treated (fractures, dislocations, sprains/strains).**

**Date** **INJURY** **Date** **INJURY**

_____
_____
_____

**Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes | No | Diabetes | Yes | No | Epilepsy | Yes | No | Cancer |
| Yes | No | Heart disease | Yes | No | Chemical dependency | Yes | No | Headaches |
| Yes | No | Arthritis | Yes | No | Tuberculosis | Yes | No | Mental Illness |
| Yes | No | High Blood Pressure | | | | | | |

**List all PRESCRIPTION, over the counter medicines, herbals, and nutritional supplements you are currently taking.**

| MEDICATION | DOSE | FREQUENCY | FORM (pill, patch, etc.) | MEDICATION | DOSE | FREQUENCY | FORM (pill, patch, etc. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

***please continue your medication list on the back of this form if needed**

**Medicine Allergies: _____**

**How much caffeine per day?_____ Cigarette smoked per day?_____ Days a week you drink alcohol?_____**

**Have you recently noted:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes | No | Falls/Slips/Trips | | | | | | |
| Yes | No | Weight loss/gain | Yes | No | Weakness | Yes | No | Menstrual Irregularities |
| Yes | No | Nausea/Vomiting | Yes | No | Fever/Chills/Sweats | Yes | No | Bladder Irregularities |
| Yes | No | Fatigue | Yes | No | Numbness or tingling | Yes | No | Rectal Bleeding |

***Form reviewed with patient:*** ***YES*** ***NO*** ***Therapist signature:_____Date:_____***