FitLife
FITNESS • AQUATICS • PHYSICAL THERAPY

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:___________________________

Are you currently:	**Have you ever had physical therapy for this condition?**
□ Working at your usual job with no restrictions □ Working at your usual job with restrictions □ Unable to work due to others medical reasons □ 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 you are currently taking (pills, injections, and skin patches):

____
____

Medicine Allergies: ____

How much caffeine per day?________ Cigarette smoked per day?__________ Days a week you drink alcohol?_______

Have you recently noted:

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:______________***