

PAST MEDICAL HISTORY FORM			Patient Name _____		
MUSCLE CONDITION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER CONDITIONS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
JOINT CONDITION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD PRESURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Poor Eye Sight	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking Packs/day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol Drinks a wk _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda Cups a wk _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor		

What types of exercise do you perform? \_\_\_\_\_  
 What things cause stress in you life? \_\_\_\_\_

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  YES  NO If yes list name(s): \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_  
 \_\_\_\_\_

List all surgeries in the past(including dates): \_\_\_\_\_

Are you pregnant?  YES  NO If yes, what week? \_\_\_\_\_

Have you had any injuries related to work or any auto accidents?  YES  NO If yes list body part & date: \_\_\_\_\_  
 \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before  YES  NO Where? \_\_\_\_\_

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian, Personal Representative

\_\_\_\_\_  
 Date