



INTEGRATIVE PHYSICAL THERAPY, LLC
Patient Medical History

Patient name: _____ Date: _____

Please check the appropriate box:

Condition	Yes	No	Details	Condition	Yes	No	Details
Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Angina	<input type="checkbox"/>	<input type="checkbox"/>		Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>		Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>		Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen Legs	<input type="checkbox"/>	<input type="checkbox"/>		Vitamin Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	
Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>		Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Loss of Balance	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>		Migraine	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>		Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		Perforated ear Drum	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma/Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy (seizures)	<input type="checkbox"/>	<input type="checkbox"/>		Back Problems/Injuries	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		Neck Problems/Injuries	<input type="checkbox"/>	<input type="checkbox"/>	
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>		Spine Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		Arm Problems/Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Leg Problems/Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>		Wrist/Hand Problems/Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		Ankle/Foot Problems/Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>		Tobacco/Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	
Raynaud's Disease	<input type="checkbox"/>	<input type="checkbox"/>		Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>		Pregnancies	<input type="checkbox"/>	<input type="checkbox"/>	

• My present activity level is: low (sedentary) medium high (very active)

• What do you hope to achieve through Physical Therapy? _____



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Prescription Medication:	Dosage	Over -the- counter Medications	Dosage	Supplements/ Vitamins	Dosage

• **ALLERGIES:** _____

Surgery	DATE	COMPLICATIONS?

• **Fall Risk Assessment:**

1. Have you fallen in the last 12 months? _____ How many times? _____
2. How did you fall? _____
3. What were your injuries? _____