Patient Number_____

Focus Physical Therapy

PATIENT HISTORY

NAME: _____ DATE: _____

Do you have a history of osteoarthritis or osteoporosis? Yes ____ No ____

Do you have a history of high blood pressure? Yes ____ No ____

Do you have any history of diabetes? Yes ____ No ____

Do you have allergies? Yes ____ No ____

List: _____

Do you have a history of heart problems or a pacemaker implant? Yes ____ No ____

Do you have any metal implants (pins, plates, screws)? Yes ____ No ____

Are you pregnant? Yes ____ No ____

Do you have any history of cancer? Yes ____ No ____

If yes; where: _____

Do you have any history of seizures? Yes ____ No ____

Have you had a stroke? Yes ____ No ____

Have you ever had physical therapy before? Yes ____ No ____

Do you smoke? Yes ____ No ____

Please list any surgeries you have had in the past _____

_____

Please list any medications you are currently taking _____

_____

Please list any supplements/ vitamins you are currently taking

_____