



Medical History Form

Name: _____ Date of Birth: _____

Chief Complaint

Why are you seeing the physical therapist today? _____

Current problem is the result of a (n): Check all that apply:

Car Accident Work Accident Injury Other _____

Please list any significant medical conditions in your past medical history:

Surgeries	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications	Dose	How Long?	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies: _____

Functional Profile

Exercise? Daily Weekly Monthly Rarely Never

What does your job entail/require functionally? _____

Patient/Patients Guardian Signature: _____