1) What areas of the body (ie. Neck, L-Hip, R-Knee, etc.) or conditions (ie. Fibromyalgia, osteoarthritis, etc.) are you currently seeking physical therapy treatment for?

2) If there are multiple areas of involvement, which region/problem is of greatest concern at this time?

3) Have you been treated for this same problem before? Yes/No  If yes, when & who treated this problem?

4) Current Level of Physical Activity: High  Medium  Low  None  List Activities (if any)

5) Please list all prescription medications you are taking, reason for medication (ie: Prozac for depression), Frequency (ie:3 times a day), and Root of Administration (ie: oral). Attach list if needed.
Medical History

Medial History (Please circle any that apply past or present):

Cardiovascular Disease

Asthma/Breathing Difficulty

Hepatitis/Liver Disease

Depression

High Blood Pressure

Congestive Heart Failure

Epilepsy/Seizures

Anemia

Diabetes (I or II)

Multiple Sclerosis

Thyroid Condition

Osteoporosis

Stroke or Heart Attack

Fibromyalgia

Neurological Condition

Chronic

Infections

Arthritis (Osteo/Rheum)

Migraines/Headaches

Eating Disorder

Lupus

Kidney/Renal Disease

Dizzy/Vertigo

Drug/Alcohol Abuse

HIV/AIDS

Cancer

(Type:________________________ Location(s):________________________ Year:________ Status:________________________)

Other:_________________________________________________________________

7) Do you have a pacemaker, internal defibrillator, insulin pump, metal fixator or any other implanted medical device(s)?

6) Are you currently pregnant or is there even a possibility you may be pregnant? Yes / No If Yes, how many weeks pregnant are you?

I certify, to the best of my knowledge that the above information is complete and true. If my medical/health status changes, I will inform you immediately.

Patient Name (Please Print):________________________________________ Date of Birth:____________________________

Patient’s Signature:________________________________________ Date:____________________________

Parent Consent to Treat a Minor (For patients under the age of 18)

Being the parent or legal guardian of _____________________________________________ (minor’s printed name), I ___________________________ (parent/guardian printed name) hereby authorize Alliance Physical Therapy, LLC to perform physical therapy evaluation and/or treatment of my minor.

Minor’s Date of Birth:________________________________________

Parent/Legal Guardian Signature:________________________________________ Date:________________________