DIRECT IMPACT PHYSICAL THERAPY
MEDICAL HISTORY FORM

Name:_____ Date:_____

Do you currently have, or have ever had in the past, any of the following conditions?

Allergy to heat:	Yes	No	GERD	Yes	No
Allergy to cold:	Yes	No	High Blood Pressure	Yes	No
Bladder/bowel disease	Yes	No	Hernia	Yes	No
Bone Disease:	Yes	No	Metal implants	Yes	No
Kidney Disease	Yes	No	Nervous Disorders	Yes	No
Cancer	Yes	No	Osteoporosis	Yes	No
Chronic Headaches	Yes	No	Pacemaker	Yes	No
Circulatory Disease	Yes	No	Pins/Needles	Yes	No
Diabetes	Yes	No	Pregnant	Yes	No
Dizziness	Yes	No	Previous Surgery	Yes	No
Fractures	Yes	No	Recent weight loss	Yes	No
Fibromyalgia	Yes	No	Seizures	Yes	No
Problems with both arms and legs at the same time				Yes	No

If YES to any of the above, please explain and give specific and appropriate details:

_____

_____

_____

Are you currently taking any medications: Yes No

If YES, please list the medication and for what conditions:

_____

_____

_____

Have you had any X-ray / CT / MRI or other diagnostic tests recently for this disorder?
YES _____ NO _____. If yes, please explain the findings as you understand them:

_____

_____

_____

Any other information you think I should know about your health, or current condition?

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