The Physical Therapy Place

Orthopedics and Pelvic Health

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Name:		**Date:**	
Date of Birth:	**Height:**	**Weight:**	**Male** ☐ **Female** ☐
Occupation:		**Hobbies:**	

Have you or an immediate family member ever been diagnosed with:

	Family	You
Cancer	N ☐ Y ☐	N ☐ Y ☐
Low/High Blood Pressure	N ☐ Y ☐	N ☐ Y ☐
Diabetes	N ☐ Y ☐	N ☐ Y ☐
Heart Disease	N ☐ Y ☐	N ☐ Y ☐
Angina/chest pain	N ☐ Y ☐	N ☐ Y ☐
Stroke	N ☐ Y ☐	N ☐ Y ☐
Arthritis	N ☐ Y ☐	N ☐ Y ☐

Do you have a history of:

Nausea/vomiting	N ☐ Y ☐
Fever/Chills/Sweats	N ☐ Y ☐
Unexplained weight change	N ☐ Y ☐
Numbness or tingling	N ☐ Y ☐
Muscular weakness	N ☐ Y ☐
Fainting spells	N ☐ Y ☐
Dizziness	N ☐ Y ☐
Night pain	N ☐ Y ☐
Bowel or bladder changes	N ☐ Y ☐
Headaches	N ☐ Y ☐

Have you had or do you experience:

Shortness of breath	N ☐ Y ☐
Allergies	N ☐ Y ☐
Asthma	N ☐ Y ☐
Bronchitis	N ☐ Y ☐
Kidney disease/stones	N ☐ Y ☐
Polio	N ☐ Y ☐
Emphysema	N ☐ Y ☐
Anemia	N ☐ Y ☐
Rheumatic fever	N ☐ Y ☐
Ulcers	N ☐ Y ☐

Have you had any recent illness, including respiratory infections or urinary tract infections? N ☐ Y ☐	Explain
Do you smoke? N ☐ Y ☐	If Yes, how many packs a day? How long have you smoked?
Do you drink alcohol? N ☐ Y ☐	How many drinks each day
Do you consume caffeine? N ☐ Y ☐	How often?
How often do you feel stress is a significant factor in your life?	Never ☐ Seldom ☐ Occasionally ☐ Regularly ☐ Always ☐
Do you exercise regularly? N ☐ Y ☐	If Yes, what type and how often?

Have you had any surgery? Please list with approximate dates.*

Any injuries or medical history?*

Please list any medications you are taking:*

* Please write & attach a separate list if necessary.