



# PAST MEDICAL HISTORY FROM

Patient Name \_\_\_\_\_

BLOOD PRESSURE	YES	NO
Hypertension	<input type="radio"/>	<input type="radio"/>
Low Blood Pressure	<input type="radio"/>	<input type="radio"/>
Normal Blood Pressure	<input type="radio"/>	<input type="radio"/>

JOINT CONDITIONS	YES	NO
Upper Extremity	<input type="radio"/>	<input type="radio"/>
Dislocation	<input type="radio"/>	<input type="radio"/>
Lower Extremity Dislocation	<input type="radio"/>	<input type="radio"/>

HEART DISEASE	YES	NO
Heart Attack	<input type="radio"/>	<input type="radio"/>
Atherosclerotic Disease	<input type="radio"/>	<input type="radio"/>
Myocardial Infarction	<input type="radio"/>	<input type="radio"/>
Rheumatic Heart Disease	<input type="radio"/>	<input type="radio"/>
Heart Murmur	<input type="radio"/>	<input type="radio"/>

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	<input type="radio"/>	<input type="radio"/>
Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>
Gout	<input type="radio"/>	<input type="radio"/>
Fibromyalgia	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Hearing Loss	<input type="radio"/>	<input type="radio"/>
Poor Eyesight	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>
Polio	<input type="radio"/>	<input type="radio"/>
Other:		

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	<input type="radio"/>	<input type="radio"/>
Tennis Elbow R/L	<input type="radio"/>	<input type="radio"/>
Back/Neck Problems	<input type="radio"/>	<input type="radio"/>
Limited Limb Movement	<input type="radio"/>	<input type="radio"/>

LUNGS	YES	NO
Asthma	<input type="radio"/>	<input type="radio"/>
Shortness of Breath	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
<input type="radio"/> None <input type="radio"/> 1-2 x week <input type="radio"/> 3-4 x week <input type="radio"/> 5+ x week	<input type="radio"/> Sitting <input type="radio"/> Standing <input type="radio"/> Light labor <input type="radio"/> Heavy labor	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> Smoking      Packs a day _____ <input type="radio"/> Alcohol         Drinks a week _____ <input type="radio"/> Coffee/Soda     Cups a week _____
What types of exercise do you perform? _____			
What causes stress in your life? _____			

Are you taking any seizure medication? <input type="radio"/> YES <input type="radio"/> NO      If yes, list name(s): _____
Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? <input type="radio"/> YES <input type="radio"/> NO      If yes, list name(s): _____
List all medications you are currently taking: _____
List all surgeries in the past two years (including dates): _____
Are you pregnant? <input type="radio"/> YES <input type="radio"/> NO      What week? _____
Have you had any injuries related to work? <input type="radio"/> YES <input type="radio"/> NO      If yes, list body part(s) and date? _____
Have you had any auto accidents? <input type="radio"/> YES <input type="radio"/> NO      If yes, list body part(s) and date? _____
Have you had Physical Therapy or Massage Therapy before? <input type="radio"/> YES <input type="radio"/> NO      If yes, where? _____

Patient/Guardian Signature |

Date