Hands On
PHYSICAL THERAPY

PATIENT PHYSICAL THERAPY HISTORY FORM

Do you have any allergies? (please list)

What type of surgeries have you had, if any:(list)

Referring Physician:_____

Family Physician:_____

Are you working: Yes No

Have you had time off work because of pain?
Yes No

What is your chief complaint? When did it begin?

List Any Medication you are currently taking:
(If list is too long, we will make a copy)

Please list any other health concerns or limitations you may have:

Do you have a history of the following?
Circle those that apply

Heart Disease

Unusual Childhood Illness

Bone Disease

Seizures/Epilepsy

Birth Defect

Lung Trouble

Diabetes

Cancer

High Blood Pressure

Low Blood Pressure

Lump, Growth, Tumor