Advanced Physical Therapy and Fitness
Patient History/ Medical Screening

Name: ____ Age: __________ Date of birth: _______________________

Check "Yes" or "No" if you have ever been told that you have…

Allergies	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Metal Implants	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Dizzy Spells	Yes ☐ No ☐	MRSA	Yes ☐ No ☐
Anxiety	Yes ☐ No ☐	Emphysema/Bronchitis	Yes ☐ No ☐	Multiple Sclerosis	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Fibromyalgia	Yes ☐ No ☐	Muscular Disease	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Fractures	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Autoimmune Disorder	Yes ☐ No ☐	Gallbladder Problems	Yes ☐ No ☐	Parkinsons	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Rheumatoid Arthritis	Yes ☐ No ☐
Cardiac Conditions	Yes ☐ No ☐	Hearing Impairment	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Pacemaker/ Defibrillator	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐	Smoking	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	High Cholesterol	Yes ☐ No ☐	Speech Problems	Yes ☐ No ☐
Circulation Problems	Yes ☐ No ☐	High/Low Blood Pressure	Yes ☐ No ☐	Strokes	Yes ☐ No ☐
COVID-19	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐	Thyroid Disease	Yes ☐ No ☐
Currently Pregnant	Yes ☐ No ☐	Incontinence	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Depression	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐	Vision Problems	Yes ☐ No ☐

In the past 3 months have you had or currently experiencing…

A change in your health	Yes ☐ No ☐	Numbness or tingling	Yes ☐ No ☐
Nausea/vomiting	Yes ☐ No ☐	Difficulty swallowing	Yes ☐ No ☐
Fever/chills/sweats	Yes ☐ No ☐	Changes in appetite	Yes ☐ No ☐
Unexplained weight change	Yes ☐ No ☐	Changes in bowel or bladder function	Yes ☐ No ☐
Change in breathing/shortness of breath	Yes ☐ No ☐	Dizziness	Yes ☐ No ☐
Any infection	Yes ☐ No ☐		

If "Yes" to any of the above, please explain and give approximate dates. Describe any other Conditions.

Have you had any fractures? YES NO
Have you had any surgery? YES NO
If yes, please describe:
____

Do you or in the past have you smoked tobacco?
YES NO If yes, ____ packs ____ years.
Last tobacco use:______________________

Do you drink alcoholic beverages? YES NO
If yes, _____ times per week.

Do you have radioactive implants? YES NO
If yes, where?
____

What activities do you have difficulty doing because of the problem that brought you to physical therapy?
____
____
____

Approximate: Height _________ Weight ___________