Medical History

Name:_____**Date of Birth:**_____**Date last updated:**_____

Please describe the problem that brings you for Physical Therapy:

Do you have any of the following:	
☐ Heart Disease/Heart Attack	☐ Diabetes
☐ High Blood Pressure	☐ Osteoarthritis
☐ Low Blood Pressure	☐ Rheumatoid arthritis
☐ Lung Disease	☐ Neurological disease (MS, Parkinsons)
☐ Cancer	☐ Peripheral vascular disease
☐ Stroke	☐ Fibromyalgia
☐ Osteoporosis/Osteopenia	☐ Infectious disease (please specify)
☐ High Cholesterol	

Do you have any of the following symptoms (anywhere in the body:)	
☐ Headaches	☐ Sudden weakness
☐ Neck pain	☐ Swelling or lumps anywhere
☐ Jaw pain	☐ Unusual fatigue/drowsiness
☐ Back pain	☐ Cough
☐ Joint pain	☐ Chest pain or tightness
☐ Chronic pain	☐ Difficulty breathing
☐ Unexplained weight loss	☐ Difficulty sleeping
☐ Recurrent infections	☐ History of substance abuse
☐ Numbness or Tingling	☐ Pacemaker/Implants
☐ Dizziness/Fainting/Light-headedness	☐ Changes in bowel/bladder
☐ Other (please specify)	☐ Blood in urine/stool/vomit/mucus
	☐ Nausea/vomiting/loss of appetite

Form provided by Atrium Physical Therapy
1115 Commerce Drive, Las Cruces NM 88011

Surgical History	Date

Medication Name	Dosage	Frequency	For

Form provided by Atrium Physical Therapy
1115 Commerce Drive, Las Cruces NM 88011