Patient Name: _____

# Past Medical History

Have you ever been diagnosed as having or have you suffered from any of the following? (Check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | High or Low Blood Pressure | | Heart Attack | | Circulatory Problems |
| | Atherosclerotic Disease | | Pace Maker | | Stroke |
| | Broken or Fractured Bones | | Osteoarthritis | | Rheumatoid Arthritis |
| | Joint Dislocations | | Multiple Sclerosis | | Muscular Dystrophy |
| | Fibromyalgia | | Gout | | Carpal Tunnel (R / L) |
| | Tennis Elbow (R / L) | | Back/Neck Problems | | Diabetes |
| | Seizures/Convulsions | | Epilepsy | | Fainting |
| | Asthma | | Emphysema | | Ulcers |
| | Cancer | | Congenital Disease | | |
| Other: | | | | | |
| | | | | | |
| | | | | | |

| Exercise | | Work Activity | | Stress Level | | Habits | | |
|---|---|---|---|---|---|---|---|---|
| | None | | Sitting | | Low | | Smoking | Packs a day |
| | 1-2 x Week | | Standing | | Medium | | Alcohol | Drinks a week |
| | 3-4 x Week | | Light Labor | | High | | Coffee/Soda | Cups a week |
| | 5+ x Week | | Heavy Labor | | | | | |

What types of exercise do you perform?:

What things cause stress in your life?:

Are you taking any seizure medication? YES NO If yes, list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well being while participating in therapy? YES NO If yes, list name: _____

List all medications you are currently taking: _____

_____

List all surgeries in the past two years (including dates): _____

_____

Are you pregnant: YES NO If yes, what week? _____

Have you had any injuries related to work? YES NO If yes, list the injury and date: _____

Have you had any Auto Accidents? YES NO If yes, list the injury and date: _____

Have you had Physical Therapy or Massage Therapy before? YES NO If yes, where: _____

_____ _____

**Signature of Patient, Parent, Guardian, Personal Representative** **Date**