FUSION PHYSICAL THERAPY

Medical History Form

Hello and thank you for choosing Fusion Physical Therapy as the provider for your current healthcare need(s)! We look forward to working with you to help make your day a little easier! To ensure you receive a complete and thorough evaluation, please provide us with your important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you.

Name:_____ Age: _____ Gender: _____

Occupation: _____

Leisure Activities: _____

ALLERGIES Are you latex-sensitive? Y N

List **any medication(s)** you are allergic to: _____

_____

List **any other allergies** we should know about:_____

Please check (√) any of the following providers whose care you are under:

___ medical doctor ___ osteopath ___ dentist ___ psychiatrist ___ psychologist

___ physical therapist ___ chiropractor ___ other: _____

Date of your last physical examination: _____

Has anyone in your immediate family (**parents, brothers, sisters**) ever been treated for any of the following?

Y N Alcoholism (chemical dependence)

Y N Cancer

Y N Depression

Y N Diabetes

Y N Heart Disease

Y N High blood pressure

Y N Inflammatory arthritis

Y N Kidney disease

Y N Stroke

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Have you **EVER** been diagnosed as having any of the following conditions?

Y N Arthritic conditions. If Y, what kind: _____

Y N Asthma

Y N Blood Clots

Y N Cancer. If Y, what kind: _____

Y N Chemical dependence (e.g. alcoholism)

Y N Circulation problems

Y N Depression

Y N Diabetes

Y N Heart problems. If Y, what kind: _____

Y N Hepatitis

Y N High blood pressure

Y N Kidney disease. If Y, what kind: _____

Y N Multiple Sclerosis

Y N Osteoporosis

Y N Stomach ulcers

Y N Stroke

Y N Thyroid problems. If Y, what kind: _____

Y N Tuberculosis

Y N Other condition(s): _____

DATE	REASON	**SURGERIES &/or HOSPITALIZATIONS**
_____	_____	
_____	_____	
_____	_____	

Would you be interested in having a future discussion about your overall health with your therapist?

Yes No Ask me again later

BODY DIAGRAM

- Please mark any area(s) of your body in which you are having ongoing symptoms.
- Please use 1-2 words to describe each symptom you are experiencing (eg. “sharp pain,” “dull pain,” “numbness,” “tingling,” “pins & needles,” etc.