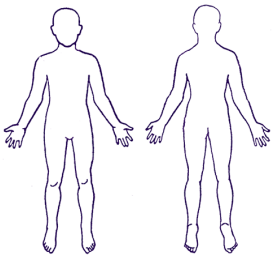
Elite
Physical Therapy & Sports Performance
A Hands On Approach to Recovery

Medical History

Name: _____ Date of Birth: _____ Date: _____



When did you first notice your symptoms? _____

Is your pain constant or intermittent? _____

What activities/motions exacerbate your symptoms? _____

What can you do to alleviate your pain? _____

What medical tests or treatments have you had? _____

_____

Do you have or have you ever had any of the following? *(Please circle below all that apply)*

Asthma/Breathing difficulties	Joint Replacement	Unexplained weight loss
Allergies	Metal Implants/Pins	Hernia
Diabetes	Night Pain	Epilepsy/Seizures
Cancer	Osteoporosis	Headaches
Heart Problems	Depression	Blood Clot
Pacemaker	Vascular Problems	Urine Leakage/Incontinence
High Blood Pressure	Vision Difficulty	Bowel or Bladder Problems
Osteoarthritis	Hearing Difficulty	Surgeries
Rheumatoid Arthritis	Dizziness or Fainting	Fibromyalgia
Stroke/TIA	Weakness	Are you pregnant?

Please elaborate on any items requiring further information: _____

_____

_____

Patient/Guardian Signature: _____

Therapist Signature: _____