PREMIER PHYSICAL THERAPY
MEDICAL HISTORY FORM

PATIENT INFORMATION

Patient Name:_____ Phone #:_____
Address:_____
Emergency contact:_____ Phone #:_____
Age:_____ Height:_____Weight:_____Occupation:_____
Primary Physician:_____
Referral Source: (Please specify doctor, advertisement, etc.)_____
Present Complaint/Symptoms:_____
_____
Part(s) of body injured or painful:_____

HISTORY OF INJURY:

Date of Injury:_____Was this an auto accident or work related?_____
_____
Are you receiving home health or chiropractic treatment at this time?_____
_____

ADULT ILLNESSES: (please check all that apply)

High Blood Pressure	_____Yes	_____No		
Gout	_____Yes	_____No		
Diabetes	_____Yes	_____No		
Thyroid Condition	_____Yes	_____No		
Heart Attack	_____Yes	_____No	Stroke ___Yes ___No	
Pacemaker	_____Yes	_____No	Seizure Disorder ___Yes ___No	

Have you ever been diagnosed with an infection or immune compromising condition?___
_____

PAST SURGERIES:

Type_____Date:_____
Type_____Date:_____
Type_____Date:_____

ALLERGIES:_____
_____
What (if any) medications are you currently taking now?_____
_____

Check any of the following that you use and state the amount used:

Alcohol _____ How much per day?_____
Tobacco _____ How much do you smoke per day?_____ How long?_____
Today's Date:_____