

Gwinnett Physical Therapy
Patient Medical History

Dear Patient: Please provide us with the following health history information. If you need help, your therapist will be glad to assist you.

Name: _____ Referring Physician: _____

1. For what condition are you seeking treatment? _____

2. Date of onset of condition _____ Date of surgery, if any _____

3. Cause of condition _____

4. Prescription medicine you are currently taking _____

5. Allergies to medication _____

6. Which of the following health care providers have you seen for this condition
 Medical Doctor Chiropractor Physical Therapist Orthopedic surgeon
 Psychiatrist Neurologist Massage Therapist Other _____

7. Have you ever been diagnosed of or experienced any of the following? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bladder/Bowel problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Deep vein thrombosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dizziness/Blackouts |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Balance problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Psych disorder | <input type="checkbox"/> Abnormal weight loss |
| <input type="checkbox"/> Smoker? | <input type="checkbox"/> Pregnant? | _____ |

8. Give us any other pertinent information that can assist us with you physical therapy _____

9. What are you goals/expectations from physical therapy _____

Gwinnett Physical Therapy

Patient Name: _____

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us:

Condition	I had	When	Family	Specify	When
Arthritis	_____	_____	_____	_____	_____
Lumgabo	_____	_____	_____	_____	_____
Rheumatism	_____	_____	_____	_____	_____
Back Problems	_____	_____	_____	_____	_____
Neck Problems	_____	_____	_____	_____	_____
Sprain/Strain	_____	_____	_____	_____	_____
Headaches	_____	_____	_____	_____	_____
Hand Problems	_____	_____	_____	_____	_____
Jaw Problems	_____	_____	_____	_____	_____
Knee Pain	_____	_____	_____	_____	_____
Hip Pain	_____	_____	_____	_____	_____
Ankle Pain	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Thank You,
Roopa Desai, PT

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