Do you have a history of:

Allergies/Asthma.....Yes.....No
Headaches.....Yes.....No
Bronchitis.....Yes.....No
Kidney Disease.....Yes.....No
Rheumatic Fever.....Yes.....No
Ulcers.....Yes.....No
Sexually transmitted disease.....Yes.....No
Seizures.....Yes.....No

Are your symptoms: (check one)

Getting worse_____ The same _____ Improving_____

How are you able to sleep at night? (check one)

Fine_____ Moderate difficulty_____ Only with Medication_____

Do you have a problem with.... (check all that apply)

Hearing_____ Vision_____ Speech_____ Communication_____

How do you learn best?

Seeing_____ Doing_____ Hearing_____

Do you or have you in the past smoked tobacco?.....Yes.....No

If yes, _____packs x _____years.
Last tobacco use_____

Do you drink alcoholic beverages?.....Yes.....No

If yes,_____ number of drinks per week.

Date of last physical examination: _____

List any current medications:

_____ _____
_____ _____
_____ _____

Is your visit to physical therapy today due to an injury/surgery?.....Yes.....No
If yes, date of injury/surgery_____
Please explain_____
_____

Signature of Patient_____ **Date:**_____

Medical history reviewed by:_____