Patient Health Information:

REFORM PHYSICAL THERAPY
Don't neglect your health, reform it

Name: _____

Date of Birth: _____

Height: _____ **Weight:** _____

Date of Onset of Pain/Injury/Condition: _____

Have you tried Physical Therapy before: Y / N

Have you had previous treatment for this pain/injury/condition? If yes, please briefly explain: (PT/Surgery/Injections)

Have you had any recent X-Rays, MRIs, CT Scans, or other diagnostic tests done for this pain/injury/condition? If yes, please list which tests were performed: _____

_____

_____

**Are you currently taking any medication s? Y / N If yes, please list the medication and the condition it treats: ***we can make a photocopy of your medication list if you have one available*

_____

_____

Do you currently have, or have you ever had, any of the following?

Diabetes: Y / N

High Blood Pressure: Y / N

Dizziness: Y / N

Chronic Headaches: Y / N

Allergy to Heat or Cold: Y / N

Kidney Problems: Y/ N

Bladder Problems: Y / N

Seizures: Y / N Hernia: Y / N

Stroke: Y / N

Pacemaker: Y / N

Metal Implants: Y / N

Cancer: Y / N Chemotherapy? Y / N

Circulatory Disease: Y / N

Bowel Problems: Y / N

Recent Weight Loss/Gain: Y / N

Nervous Disorder: Y / N

Currently Pregnant: Y / N

Osteoporosis/Bone Disease: Y / N

If you answered YES to any of the above, please explain and give appropriate detail:

_____