



MEDICAL HISTORY Please check if you have ev

- Arthritis
- Osteoporosis
- Heart problem
- Lung Problem
- Diabetes
- Head Injury
- Muscular dystrophy
- Seizures/epilepsy
- Thyroid problem
- Cancer
- Hepatitis
- Repeated infections
- Skin diseases
- Pacemaker
- Hernia
- Concussion
- AIDS/HIV
- Appendicitis
- Other _____
- Broken bones
- Blood disorders
- High blood pressure
- Stroke
- Hypoglycemia (low blood sugar)
- Multiple Sclerosis
- Parkinson disease
- Allergies
- Developmental (growth) problem
- Tuberculosis
- Kidney Problems
- Ulcers/stomach problems
- Depression
- Fibromyalgia
- Migraines
- Asthma
- Anemia
- Circulation/vascular problems

Within the past year have you had any of the following?

- Chest pain
- Heart palpitations
- Cough
- Hoarseness
- Shortness of breath
- Dizziness or blackouts
- Coordination problems
- Headaches
- Fever/chills/sweats
- Difficulty walking
- Joint pain or swelling
- Pain at night
- Difficulty sleeping
- Loss of appetite
- Nausea/vomiting
- Difficulty Swallowing
- Bowel problems
- Weight loss/gain
- Urinary problems
- Weakness in arms or legs
- Loss of balance
- Hearing problems
- Vision problems
- Other _____

Men: Prostate disease Yes No

Women: Pelvic inflammatory disease Endometriosis

- Trouble with your periods Complicated pregnancy
- Currently pregnant
- Other _____

Have you fallen in the past 12mo's Yes No
If yes, how many times? _____

Have falls resulted in injury? Yes No
Do you have difficulty with walking/ balance? Yes No

MEDICATIONS

List all medications (Prescriptions and non-prescription) you are Currently taking.

Name	Dosage (mg)	Frequency(# per day)

HISTORY OF PRESENT ILLNESS

Describe the general problem for which you are here today:

When did this problem Begin?
Month Day Year

Did you have Surgery for this Problem? No Yes
Date of Surgery
Month Day Year

Did you stay overnight in the Hospital? No Yes
Date of Discharge from Hospital
Month Day

How did this injury happen? _____

Have you ever had a similar problem before?

No Yes What did you do for the problem? _____
What makes the problem(s) better? _____

What makes the problem(s) worse? _____

Current weight bearing/lifting restrictions: _____

Are you Right Handed Left Handed

Are you seeing anyone else for the problem(s)?

- Acupuncturist Cardiologist Chiropractor
- Dentist Family Doctor Internist
- Neurologist Osteopath Pediatrician
- Podiatrist Rheumatologist Message Therapist
- Obstetrician/gynecologist Occupational Therapist
- Orthopedic Surgeon Other _____

What diagnostic tests have been performed for this problem?
 X-ray CT scan MRI Other _____

WORK RELATED INJURIES

Is the injury related to a work injury? No Yes

Date of Injury: _____

Current work status:

- Full time regular duty Full time light duty
- Part time regular duty Part time light duty
- Unable to work due to injury Unemployed

Describe your regular work duties prior to your injury: _____

Current work restrictions: _____

CAR ACCIDENT INJURIES

Is the injury related to a car accident? No Yes

Date of Accident: _____

Describe in detail what happened: _____

Were you taken in an ambulance to a hospital? No Yes

If No, when did you first seek medical attention for your injuries? Exact date: _____

Were you ever treated for this pain/problem prior to this accident?
 No Yes Explain: _____



HIPAA

Patient's Written Acknowledgement of Notice of Privacy Practices:

I _____, acknowledge that I have been granted access to the notice of privacy practices and was given the ability to request a copy of 360 Physical Therapy's Notice of Privacy Practices and fully understand. I further acknowledge I have had all my questions answered to my satisfaction.

I hereby authorize 360 Physical Therapy to disclose my protected health information to the following:

_____	_____
Name	Relationship to patient

_____	_____
Name	Relationship to patient

Patient/ Guardian Signature: _____ Date: _____

Consent to treat a minor

I hereby state that I am the legal guardian for the below referenced patient and I authorize the physical therapists and whomever they may designate as assistants at 360 Physical Therapy LLC and/or Human Performance Center to administer physical therapy treatment care as deemed necessary to my minor child. I understand that at any time I am responsible for communicating any questions I may have in regards to treatment to the treating therapist or supervision therapist at the facility. I further understand it is my responsibility to understand upon conclusion of the evaluation appointment I should understand the indications and contraindications for treatment and should notify the evaluating therapist if I do not understand. This consent shall remain in effect through the course of treatment unless revoked in writing.

Printed Name of Parent or Legal Guardian: _____

Address: _____ Phone: _____

Signature of Parent or Legal Guardian: _____

Witness: _____ Date: _____