Physical Therapy & Vestibular Rehabilitation

Blood Pressure

Medical History

Name: _____ Age: _____ Date: _____
Height:___ft___in__ **Weight:**_____lbs_

Please complete this form to the best of your ability. If you have any questions, please ask the receptionist.
Have you ever experienced any of the following *(mark in column Y for yes, N for no)*:

	Y	N		Y	N		Y	N
Bladder difficulties			Headaches			Osteoporosis/osteopenia		
Bowel difficulties			Heart disease			Recent fever		
Depression/anxiety			Hypertension			Seizures		
Diabetes			Lung disease			Smoker		
Dizziness			Obesity			Taking steroids		
Currently pregnant			Circulatory disorder			**COVID Vaccine**		
Cancer			*circle*: upper/lower Extremities			**Positive COVID Test**		

Where: _____ When: _____

Eye health/surgeries_____ *circle*: cataracts macular degeneration glaucoma
Provide Summary of Reason for Visit:_____

_____

_____ Date of Injury:_____

Past medical history: _____

_____

_____

_____

_____

Previous therapy/surgeries/injuries: _____

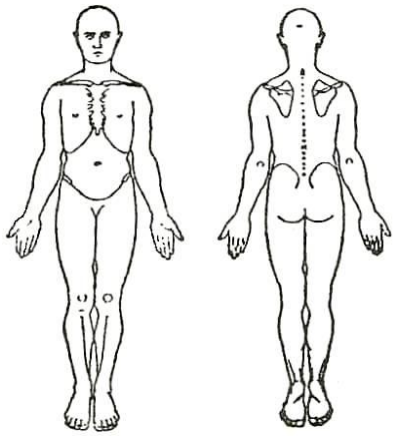
_____

_____

_____

Diagnostic tests: _____
MRI: Date: _____Body Part: _____Location: _____

Rate your pain on a scale of 0 to 10: at rest _____ with activity _____
On the body chart below, please circle areas of pain and mark areas of numbness with an X.



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List all prescriptions, over-the-counters, herbals, vitamins and dietary supplements:

Name	Dosage	Frequency	Administration (oral, spray, injectable, etc.)