Synergy Physical Therapy
Medical History

Patient Name: ___________________________________ **Date of Injury:** ____________________________
Body Part: ___________________________ **Description of Injury:** _________________________________

For Insurance/Documentation the following information is needed:
Height: _____________ **Weight**: __________
Pain Level from 1 to 10, with 10 being the worst: Worst: ________ **Best**: _________ **Current**: ________

Do you have any of the following symptoms/conditions? (Please Circle Y for Yes, N for No)

Diabetes	**Y**	**N**	Bowel/Bladder Abnormalities	**Y**	**N**	Dizziness/Fainting	**Y**	**N**
Chest Pain/Angina	**Y**	**N**	Urine Leakage	**Y**	**N**	Recent Fractures	**Y**	**N**
High Blood Pressure	**Y**	**N**	Asthma/Breathing Difficulties	**Y**	**N**	Surgeries	**Y**	**N**
Heart Disease	**Y**	**N**	Stroke/CVA	**Y**	**N**	Skin Abnormalities	**Y**	**N**
Heart Attack	**Y**	**N**	Smoke?	**Y**	**N**	Sexual Dysfunction	**Y**	**N**
Heart Palpations	**Y**	**N**	Allergies to Medication	**Y**	**N**	Epilepsy	**Y**	**N**
Pacemaker	**Y**	**N**	Allergies to Heat/Cold	**Y**	**N**	Nausea/Vomiting	**Y**	**N**
Headaches	**Y**	**N**	Other Allergies?	**Y**	**N**	Ringing in your ears	**Y**	**N**
Kidney Problems	**Y**	**N**	Hernia	**Y**	**N**	Rheumatoid Arthritis	**Y**	**N**
Are you Pregnant?	**Y**	**N**	Seizures	**Y**	**N**	Special Diet Guidelines	**Y**	**N**
Cancer	**Y**	**N**	Metal Implants	**Y**	**N**	Hypoglycemia	**Y**	**N**
Osteoporosis	**Y**	**N**	Other?	**Y**	**N**			

If "Yes" to any of the above please explain: ____
____
____

List any exercise or activities you are currently participating in: ____________________________________
____

Due to insurance requirements an up to date medication list must be on file. Should you need more room please use additional sheet. If you do not wish to disclose your medication list please check the line below.

Classification (prescription, over-the-counter, herbal, vitamin/dietary supplement)	Name	Frequency & Dosage	Route of Administration (oral, injection, topical)

______ **I do not wish to disclose my medication list at this time or I am not taking any medication.**

Patient/Guardian Signature: ____ **Date**: ___________________

Therapist Signature: ____ **Date**: ___________________