South Mountain
Physical Therapy

Medical History Form

(Please Print)

GENERAL INFORMATION

Todays Date: File #:

First Name: Last Name

Date of Birth: Age: Sex: Male Female

MEDICAL HISTORY

If you have had previous or current experience of the following, please circle and describe below:

Surgery	Yes	No	Tuberculosis	Yes	No
High/Low Blood pressure	Yes	No	Lung Disease	Yes	No
Heart Attack	Yes	No	Blood Clots	Yes	No
Pace Maker	Yes	No	Diabetes	Yes	No
Other Heart Disease	Yes	No	Cancer	Yes	No
Hepatitis B/C	Yes	No	Osteoporosis	Yes	No
HIV/AIDS	Yes	No	Pregnancy	Yes	No
Hyper/ Hypo Thyroid	Yes	No	Neurological Disorder	Yes	No
Asthma	Yes	No	Fractures	Yes	No

Recent Fever, chills, night sweats, shortness of breath, decreased appetite: Yes No

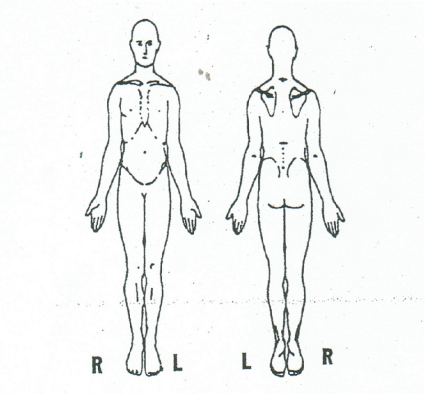
Explain yes checked: *(Surgery Date etc.)*

Imaging: *(x-rays, MRI CT scan etc. date and result if known)*

CURRENT MEDICATIONS (PLEASE LIST)

Allergies To:

CURRENT SYMPTOMS: IDENTIFY PAIN LOCATION AND TYPE



Rate your pain: *(please circle)* 0 1 2 3 4 5 6 7 8 9 10

Signature_____ Date_____

3230 E. Baseline Rd Ste. 101 Phoenix, Az. 85042 (32nd Street/ Baseline Rd)
P: 602-438-9773 Fax: 602-438-9776