foundations
PHYSICAL THERAPY

285A Pascack Road
Washington Township, NJ 07676
201-358-9200 (P) 201-358-9201 (F)

MEDICAL HISTORY

Name: _____

Age: _____ Current Height: _____ Current Weight: _____

*Please indicate if you have a personal history of any of the following:

Allergies	YES	NO	Hepatitis	YES	NO
Anemia	YES	NO	High Cholesterol	YES	NO
Anxiety	YES	NO	High/ Low Blood Pressure	YES	NO
Arthritis	YES	NO	HIV/ AIDS	YES	NO
Asthma	YES	NO	Incontinence	YES	NO
Autoimmune Disorder	YES	NO	Kidney Problems	YES	NO
Cancer	YES	NO	Metal Implants	YES	NO
Cardiac Conditions	YES	NO	MRSA	YES	NO
Cardiac Pacemaker	YES	NO	Multiple Sclerosis	YES	NO
Chemical Dependency	YES	NO	Muscular Disease	YES	NO
Circulation Problems	YES	NO	Osteoporosis	YES	NO
Depression	YES	NO	Parkinson's Disease	YES	NO
Diabetes	YES	NO	Rheumatoid Arthritis	YES	NO
Dizzy Spells	YES	NO	Seizures/ Epilepsy	YES	NO
Emphysema/ Bronchitis	YES	NO	Smoking	YES	NO
Fibromyalgia	YES	NO	Speech Problems	YES	NO
Fractures	YES	NO	Strokes	YES	NO
Gallbladder Problems	YES	NO	Thyroid Disease	YES	NO
Headaches	YES	NO	Tuberculosis	YES	NO
Hearing Impairments	YES	NO	Vision Problems	YES	NO

Have you undergone any of the following testing? (please provide dates)

X-ray _____ MRI_____ EMG_____ Cardiac Stress Test_____

Bone Density Scan _____
Other_____

Are you currently pregnant? YES NO If Yes, what is your due date? _____

How would you rate your current level of stress? (circle one) LOW MEDIUM HIGH

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Is your current injury the result of a fall? YES NO If yes, how many falls have you experienced in the past year? _____

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MEDICAL HISTORY

Are you currently taking medications? YES NO

If yes, please list all medications with dosages below.

MEDICATION	DOSAGE
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Have you undergone any surgeries? YES NO

If yes, please list all surgeries with dates below.

SURGICAL PROCEDURE	DATE
1.	
2.	
3.	

4.	
5.	