MEDICAL HISTORY FORM

Patient Name:_____ Date of Birth:_____

Date of Injury (approximate): _____ Date of first doctor visit for this injury:_____

Date and type of surgery (if any) for this condition: _____

Employer: _____ Occupation:_____

Marital Status: _____ Spouse's Name: _____

☐ Are you a past patient of Achieve Physical Therapy? **Y or N**

☐ Are you currently missing work due to this injury? **Y or N**

☐ Has your working status been modified? **Y or N**

☐ Have you had other medical/rehab services for this injury? **Y or N** If Yes, please **LIST**:

Please indicate all of the following conditions that apply, either presently or in the past:

	High Blood Pressure		Chronic Obstructive Pulmonary Disease		Diabetes
	Gout		Emotional/Psychological		Pacemaker
	Varicose Veins		Angina, Heart Attack		Dizziness or Fainting
	Currently Pregnant		Heart Surgery, Date:		Stroke
	Epilepsy/Seizure		Arthritis		Cancer
	Allergies, please specify:				
	Other:				

☐ Are you currently taking medication(s)? **Y or N** If Yes, please **LIST**:

What was your primary reason for choosing Achieve Physical Therapy? **(Please check only one)**

☐ **My physician referred me DIRECTLY to Achieve Physical Therapy** Physician's name:
☐ **My physician gave me a LIST of physical therapy providers and your office was listed** Physician's name:
☐ **I was referred to Achieve Physical Therapy by a FRIEND, COLLEAGUE , or FAMILY MEMBER** Please list their name(s):
☐ **I am a past patient**
☐ **Other (please specify):**