Name:_____

Phone:_____

Date:_____

Do you have or have you ever had any of the following:

Osteoporosis/Osteopenia.....Yes/No
Osteoarthritis.....Yes/No
Rheumatoid Arthritis.....Yes/No
Heart Problems.....Yes/No
High Blood Pressure.....Yes/No
Lung or Breathing Problems.....Yes/No
Stroke.....Yes/No
Diabetes.....Yes/No
Head Injury.....Yes/No
Allergies.....Yes/No
Seizures.....Yes/No
Thyroid Problems.....Yes/No
Cancer.....Yes/No
Tuberculosis.....Yes/No
Hepatitis.....Yes/No
Kidney Disease.....Yes/No
Skin Disorder.....Yes/No
Mental Health Disorder.....Yes/No
Depression.....Yes/No
Alcoholism.....Yes/No

If yes to any above, please explain:

_____

_____

Surgeries:

_____

_____

Other medical problems:

_____

_____

Do you have problems with any of the following:

Hearing.....Yes/No
Vision.....Yes/No
Speech.....Yes/No

Emergency Contact Name and Phone:

_____

In the past 3 months have you had any of the following:

Any falls.....Yes/No
Chest Pain.....Yes/No
Shortness of Breath.....Yes/No
Dizziness.....Yes/No
Loss of Consciousness.....Yes/No
Weakness in Arms or Legs.....Yes/No
Headaches.....Yes/No
Weight Loss or Gain.....Yes/No
Infection.....Yes/No

Are you pregnant?.....Yes/No

Do you smoke?.....Yes/No

Please list all medications including dosage, frequency, and delivery route (or attach a separate sheet):

_____

_____

_____

_____

_____

_____

I attest that the above information is correct to the best of my knowledge. I also hereby give my consent to receive physical therapy services from Mountain View Therapy Services, LLC.

_____

Patient Signature Date