

CATZ PHYSICAL THERAPY

Patient History

Please complete all requested information.

Name: _____

Sex: M F Age: _____

Referring Doctor: _____

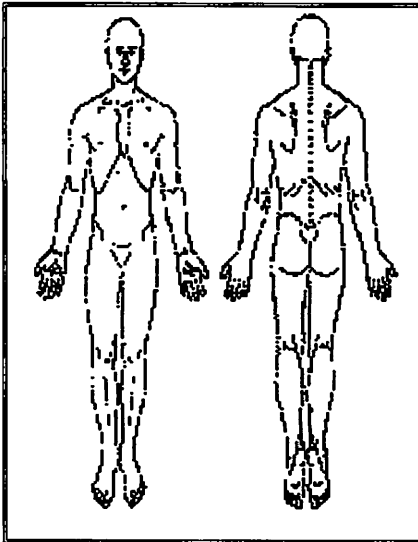
Date of Birth: _____

Current Injury _____

Date of Surgery _____

Have you ever had: (If Yes, please explain)

- High Blood Pressure no yes
- Heart or circulation Disorders no yes
- Seizures no yes
- Dizzy Spells no yes
- Cancer no yes
- Arthritis/Osteoarthritis no yes
- Osteoporosis no yes
- Immune Deficiency Disease no yes
- Diabetes no yes
- Stroke no yes
- Nervous Disorders no yes
- Other no yes



Please mark symptoms with symbols

- XXX Sharp localized pain
- /// Burning
- 000 Numbness and Tingling
- ^^^ Shooting Pain

1. Please explain any items answered yes:

2. Please list surgeries you have had and dates, if possible:

3. Please list recent diagnostics studies (X-rays, MRI, CT Scan):

4. Do you have any metal anywhere in your body; pins/plates post fracture, or pacemaker? No / Yes

5, (For women only) Are you now pregnant? No / Yes

6. Do you have any abnormal trouble with vision? No / Yes Hearing? No / Yes

7. List any Allergies you have: _____

8. Have you ever taken steroids or anti-coagulants for an extended period of time? No / Yes

9. Have you had an unusual weight gain or loss lately? No / Yes

10. List any medications you are now taking: _____

11. Have you ever had physical therapy treatments before? No / Yes If yes, please indicate when and for what problem:

12. Describe briefly the history of your present Accident, Injury, or Illness Onset Date: _____
Description: _____

13. Date of next Doctor's appointment: _____