SYNERGY PHYSICAL THERAPY

MEDICAL HISTORY FORM:

Patient's Name: _____ Today's Date: _____

Referring MD: _____ Date of onset/injury: _____

Primary Care MD: _____ Date of next MD appt: _____

Reason for attending physical therapy: _____

Are you currently working: Y N

Have you been recently hospitalized? Y N If yes, when/ where? _____

Have you had prior Physical Therapy or Chiropractic Care during this calendar year? Y N
If yes, where? (circle one): Hospital Outpatient center Home Health

How many visits received/ how long was treatment for? _____

Current medications? _____

☐ **See attached medication list**

Allergies: _____

Medicare patients: Weight _____ Height: _____

Please check any of the conditions that you ever had or have now:

☐ **Anemia**	☐ **Depression**	☐ **Hepatitis**	☐ **Pacemaker**
☐ **Arthritis**	☐ **Diabetes**	☐ **High Blood Pressure**	☐ **Respiratory Problems**
☐ **Cancer**	☐ **Dizziness/Fainting**	☐ **Kidney Problems**	☐ **Seizures**
☐ **Cardiac**	☐ **Headaches**	☐ **Metal Implants**	☐ **Thyroid problems**

Any other medical conditions: _____

Are you currently pregnant? Y N N/A If yes, _____ Weeks/Month

Signature of patient: _____

Signature of Therapist: _____