SHAPE PHYSICAL THERAPY
YOUR COMEBACK IS ALWAYS GREATER THAN THE SETBACK

Past Medical History

Please circle any condition that you currently have or have had in the past:

High Blood Pressure	Stroke	Arthritis
Lung Disease/Problems	Cancer	Kidney Disease
Heart Disease/Problems	Diabetes	Liver Disease
Asthma/Allergies	Pacemaker	Angina
Circulation/Bleeding Problems	Osteoporosis	Fibromyalgia

Any other conditions not listed: _____

Are you allergic to latex? **YES** **NO**

Do you smoke? **YES** **NO**

Are you pregnant? **YES** **NO**

Do you have an advanced directive? **YES** **NO**

Are you currently taking any medications? **YES** **NO**

If yes, please list ALL medications, the dosage, and how often that you are currently taking:

_____

_____

_____

Please list past surgeries and dates:

_____

_____

_____

What are your goals for physical therapy?

_____

_____

Patient Name_____Signature_____Date_____