ABILENE PHYSICAL THERAPY AND SPORTS REHAB
103 NW 15th St
Abilene, KS 67410
Phone: (785) 263-3646 **Fax**: (785) 263-3689

PATIENT HISTORY

Patient Name ____ **Age** _______

PATIENT MEDICAL HISTORY

Alcohol use ☐ Yes ☐ No
How much ________________
Anemia ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Bladder disorder ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Balance ☐ Yes ☐ No
Pregnant ☐ Yes ☐ No
Neck/Back pain ☐ Yes ☐ No
Autoimmune dz ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Fainting spells ☐ Yes ☐ No
Hearing prob. ☐ Yes ☐ No
Hepatitis (B or C) ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Bleeding disorder ☐ Yes ☐ No

Latex sensitive ☐ Yes ☐ No
Smoking ☐ Yes ☐ No
How much __________
Stomach disorder ☐ Yes ☐ No
Thyroid prob. ☐ Yes ☐ No
Tremors ☐ Yes ☐ No
Parkinson's ☐ Yes ☐ No
Lymphedema ☐ Yes ☐ No
Neuropathy ☐ Yes ☐ No
Fibromyalgia ☐ Yes ☐ No

FALLS ☐ Yes ☐ No __________ How many in last 12 months __________ Injury

MEDICATIONS ______________________ **DOSAGE** ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

ALLERGIES ____

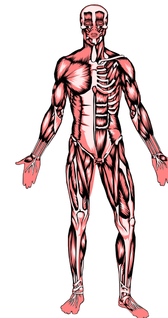
PREVIOUS SURGERIES ____

CARDIOVASCULAR HISTORY

High Blood pressure ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Fast Heartbeats ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Heart attack ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No
Irregular heartbeats ☐ Yes ☐ No
Angina ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Stroke ☐ Yes ☐ No

Please "X" injury or pain area



Pain Scale (please circle)
0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

FAMILY MEDICAL HISTORY

Please list any family medical history: (living or deceased) What family member?

Cancer	☐ Yes	☐ No	Relation: ____________________	☐ Living	☐ Deceased
Heart disease	☐ Yes	☐ No	Relation: ____________________	☐ Living	☐ Deceased
High blood pressure	☐ Yes	☐ No	Relation: ____________________	☐ Living	☐ Deceased
Diabetes	☐ Yes	☐ No	Relation: ____________________	☐ Living	☐ Deceased
Back pain	☐ Yes	☐ No	Relation: ____________________	☐ Living	☐ Deceased
Neck pain	☐ Yes	☐ No	Relation: ____________________	☐ Living	☐ Deceased

Patient Signature: ________________________________ Date: ________________

☐ PT reviewed medications/dosage and pain assessment with patient.