725 N. Wilcox
Castle Rock, CO 80104
(720) 457-5535

MEDICAL HISTORY FORM

(Please print neatly)

Today's Date: ____ / ____ / _____

Patient Name: _____ Date of Birth: ____ / ____ / _____

PATIENT INFORMATION

Are you presently working? ☐ Yes ☐ No Occupation: _____

Primary Care Physician: _____ Phone #: _____

Date of next scheduled physician's visit: ____ / ____ / _____ Are you pregnant? ☐ Yes ☐ No

HISTORY OF INJURY

Type of injury: _____ Date of injury/onset: ____ / ____ / _____

Have you experienced these symptoms before? ☐ Yes ☐ No

Have you had a related surgery? ☐ Yes ☐ No If yes, surgery date: ____ / ____ / _____

Referring Physician: _____ Phone #: _____

MEDICAL HISTORY

Do you have or have you had any of the following?

Diabetes	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Chest Pain/Angina	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Heart Palpitations	☐ Yes	☐ No	Metal Implants	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Dizziness/Fainting	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Fractures	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Surgeries	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Skin Abnormalities	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Nausea/Vomiting	☐ Yes	☐ No
Bowel/Bladder Abnormality	☐ Yes	☐ No	Ringing in your ears	☐ Yes	☐ No
Pelvic Pain	☐ Yes	☐ No	Rheumatic Arthritis	☐ Yes	☐ No
Urine Leakage	☐ Yes	☐ No	Smoking	☐ Yes	☐ No
Asthma/Difficulty Breathing	☐ Yes	☐ No	Liver/Gallbladder Problems	☐ Yes	☐ No
Other: _____					

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

_____

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MEDICAL HISTORY FORM

(Please print neatly)

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____

Are you presently taking any medications? ☐ Yes ☐ No

If **yes**, please list what medication and for what condition:

_____

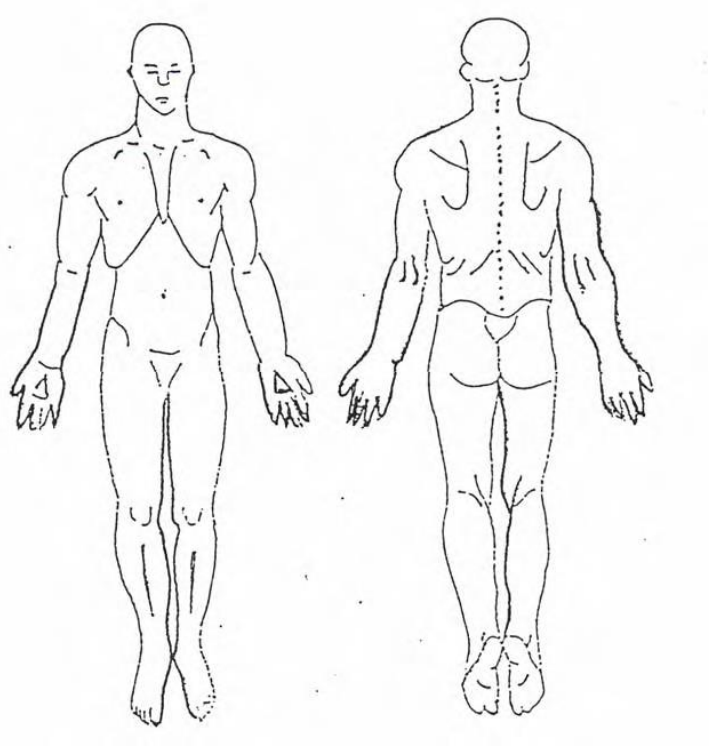
_____

Do you participate in any sports, exercise program or activities on a regular basis? ☐ Yes ☐ No If yes, please explain:

_____

_____

Please indicate below where your symptoms are located:



AVERAGE PAIN INTENSITY

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

CONSENT TO TREAT

I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have No Limits PT provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature_____ Date _____

Signature of Patient/ Guardian_____ Date _____