North End
PHYSICAL THERAPY

PATIENT PAST MEDICAL HISTORY

Patient Full Name _____ Today's Date _____

Please check all symptoms / illnesses that you have currently or have had in the past six (6) months:

- ☐ Cancer
- ☐ Heart Problem/ Disease
- ☐ Arthritis (OA, Rheumatoid)
- ☐ Smoking/ Tobacco Use
- ☐ Severe Night Pain
- ☐ Poor Circulation
- ☐ Loss of Appetite
- ☐ Swelling in Limbs
- ☐ Kidney Disorder
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Headaches
- ☐ Coronary Artery Disease
- ☐ Loss of Consciousness
- ☐ Loss of Sleep
- ☐ Irregular Heartbeat
- ☐ Liver Disorder
- ☐ Bowel/ Bladder Problems
- ☐ Kidney Disease
- ☐ Difficulty Breathing
- ☐ Thyroid Problems
- ☐ Epilepsy/ Seizures
- ☐ Loss of Balance
- ☐ Sweats
- ☐ Pacemaker
- ☐ Other _____
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Chemical Dependency
- ☐ Frequent Falls
- ☐ Difficulty Hearing/ Aid
- ☐ Loss of Weight
- ☐ Changes in Vision
- ☐ Depression

List all medications you are currently taking: _____

Describe your exercise regimen or activities that you performed regularly prior to your injury: _____

Any hospitalizations or surgeries in the last six (6) months? _____

If your job is physically demanding, please describe your duties: _____

What are your goals for physical therapy? _____

Is there anything else you would like us to know about your injury? _____

Males—Date of last prostate exam _____

Females—I am or may be pregnant: ☐ Yes ☐ No

Date of last breast exam _____

Date of last pelvic exam _____

AUTHORIZATION FOR TREATMENT

I certify that the information I have provided is correct to the best of my knowledge. I will not hold my physical therapist or any members of the staff responsible for any errors that I may have made in completing my patient forms.

I authorize North End Physical and Craniosacral Therapy to provide prescribed treatment based on my evaluation.

Signature _____ Date _____