PEAK PHYSICAL THERAPY SPORTS PERFORMANCE

Medical History

Patient Name_____Age_____

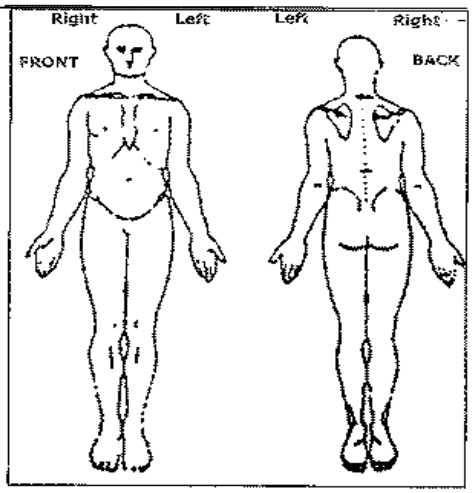
Type of Injury/Condition_____

Type of Surgery & Date_____

Next Doctor's Appointment?_____

Describe previous treatment for this condition_____

_____



Have you received physical therapy treatment this year? YES / NO

Have you received speech therapy treatment this year? YES / NO

Have you received Home Health Care via Medicare this year? YES / NO

Have you received Chiropractic treatment this year? YES / NO

Have you had any imaging performed:

☐ X-Ray ☐ CT Scan

☐ MRI ☐ Doppler

☐ Ultrasound

Have you recently noted:

☐ Weight Loss/ Gain ☐ Nausea / Vomiting ☐ Fatigue

☐ Weakness ☐ Fever / Chills / Sweats ☐ Numbness / Tingling

☐ Pregnant / IUD ☐ Headaches ☐ Change In Vision Or Hearing

☐ Pain At Night ☐ Cramps In Legs When Walking ☐ Insomnia

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

☐ Surgeries ☐ Loss of Consciousness ☐ Fractures

☐ Sprains / Strains ☐ Diabetes ☐ Blood Pressure Problems

☐ Heart Problems ☐ Cancer ☐ Motor Vehicle Accident

☐ Circulation Problems / Clots ☐ Asthma / Breathing Problems ☐ Lung Disease

☐ Easy Bruising / Bleeding ☐ Leg / Ankle Swelling ☐ Urinary Problems / Infections

☐ Indigestion / Heartburn ☐ Fainting ☐ Allergies / Skin Sensitivity

☐ Any Previous Injury that may affect current care: _____

_____

Explain & give approximate dates for any items you indicated above_____

Are you currently taking medications? YES / NO Name or Type of Medication _____

_____

Type Of Pain: SHARP / BURNING / ACHING / TINGLING / NUMBNESS / OTHER_____

Rate your pain (average) on a 1-10 scale (1=minimal 10=severe)_____

What do you hope to get out of your treatment?_____

_____

What are your physical or fitness goals:

Currently_____

_____

In 6 Months_____

In 12 Months_____

Is there anything else you would like to include or ask your physical therapist?_____