Do you have a history of:

Allergies/Asthma..Yes..........No
Headaches..Yes..........No
Bronchitis..Yes..........No
Kidney Disease..Yes..........No
Rheumatic Fever..Yes..........No
Ulcers..Yes..........No
Sexually transmitted disease.......................Yes..........No
Seizures...Yes..........No

Are your symptoms: (check one)

Getting worse________ The same ________ Improving________

How are you able to sleep at night? (check one)

Fine__________ Moderate difficulty_________ Only with Medication_______

Do you have a problem with.... (check all that apply)

Hearing________ Vision_________ Speech________ Communication______

How do you learn best?

Seeing_________ Doing________ Hearing_________

Do you or have you in the past smoked tobacco?......................Yes..........No

If yes, _________packs x __________years.

Last tobacco use______________________

Do you drink alcoholic beverages?...Yes........No

If yes,____________ number of drinks per week:

Date of last physical examination: ________________________________

List any current medications:

________________________________ ______________________________
________________________________ ______________________________
________________________________ ______________________________

Is your visit to physical therapy today due to an injury/surgery?.........Yes.........No

If yes, date of injury/surgery____________________

Please explain____
____

Signature of Patient___________________________ **Date:**__________________

Medical history reviewed by:____