

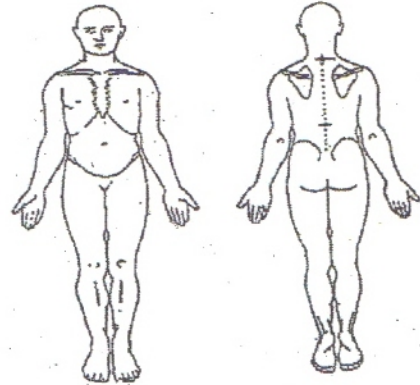
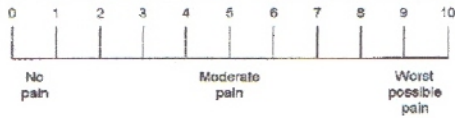
## Carolina Physical Therapy & Sports Medicine Patient History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Therapy: \_\_\_\_\_

Please indicate area's that your are currently having problems by marking on the diagram to the right.

Please circle the number that best describes your current pain.



Are you currently receiving or have you previously received any therapy or chiropractic services this year.    Y   N

Are you currently experiencing or have you experienced any of the following?

Heart Disease	Yes	No	Kidney Problems	Yes	No
High Blood Pressure	Yes	No	Seizure	Yes	No
Vertigo/Dizziness	Yes	No	Cancer	Yes	No
Metal Implants	Yes	No	Anxiety/Depression	Yes	No
Stroke	Yes	No	Allergies/Skin	Yes	No
Diabetes	Yes	No	Hernia	Yes	No
Pacemaker	Yes	No	Shortness of Breath	Yes	No
Headaches	Yes	No	Pregnant/IUD	Yes	No
Hepatitis A/B/C	Yes	No	HIV/AIDS	Yes	No
Smoke __pack/day	Yes	No	Numbness/Tingling	Yes	No
Weight Loss/gain	Yes	No	Pain with cough/sneeze	Yes	No

Other Medical Conditions: \_\_\_\_\_

Have you fallen in the past year? (If yes, how many times?) \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Please list any medications or supplements you are currently taking: \_\_\_\_\_

Please describe type of injury and approximate date of onset: \_\_\_\_\_

What therapy goals would you like to achieve? \_\_\_\_\_

I am consenting to evaluation and treatment at Carolina Physical Therapy & Sports Medicine. I understand that after an evaluation is performed my therapist will outline a plan of care. I understand that I may refuse any portion of treatment at any time. I understand that Carolina Physical Therapy & Sports Medicine reserves the right to discontinue my treatment if I should miss three consecutive treatments or have excessive cancellations without communicating to Carolina Physical Therapy & Sports Medicine.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_