



FOLSOM PHYSICAL THERAPY
and Training Center
HEALTH HISTORY

Yes No

- Osteoporosis
- Diabetes
- Hypertension (High Blood Pressure)
- Heart Disease
- Cancer or Tumors
- Lung Problems
- Stomach Problems
- Kidney or Liver Problems
- Arthritis or other Joint Problems
- Seizures or Nervous Disorders
- Allergies
- Dermatitis or any Skin Problems
- Eye Problems
- Hernias
- Unusual/ Frequent Headaches
- Are there any other health problems not mentioned above? If so please describe:**

- Do you have any family history of any of the above problems? If so, please describe:**

- Are you pregnant?
- Do you have any implants? (i.e. joint replacements or pacemakers)?
- Are you awakened at night?
- Do you ever have uncontrolled leakage of urine, gas, or feces?
- Have you ever taken any medications for longer than a few weeks?
- Have you ever taken any steroid medications such as cortisone?
- Are you currently taking any medications?
- Have you ever been hospitalized?
- Have you ever had surgery?
- Have you ever been placed in a splint, cast, ace wrap or sling?
- Have you ever had to use crutches, canes, a walker, or wheelchair?
- Do you use any shoe lifts, braces, corsets, or supports?
- Are you currently treated by any other doctor, therapist, chiropractor, masseuse, podiatrist, etc.

Do you consider your health to be: Excellent, Good, Fair, Poor

Date of Last Physical Exam: _____ Physician: _____

Reason for Today's Visit: _____

Current Physician: _____ Who Recommended you to us? _____

Patient/Guardian Signature: _____ Date: _____