ProFitness Physical Therapy

Name_____

Do you have any history of heart problems? □ Yes □ No

Do you have any history of cancer? □ Yes □ No

Do you have any history of diabetes? □ Yes □ No

Do you have any history of surgeries? □ Yes □ No

Do you have any history of breathing problems? □ Yes □ No

Do you have any history of kidney problems? □ Yes □ No

Do you have any history of bladder/bowel problems? □ Yes □ No

Do you have any history of liver problems? □ Yes □ No

Do you have any history of fatigue and/or weakness? □ Yes □ No

Do you have any history of fevers, chills, sweats, malaise, and/or nausea? □ Yes □ No

Have you lost 10 lbs or more in the past year without trying to lose weight? □ Yes □ No

Females: Have you had any changes in menstruation? □ Yes □ No

If you answered "Yes" above, please explain:_____

_____

_____

Please list any other past medical history:_____

_____

Please list all the medications you are taking:_____

_____

Are you allergic to latex? □ Yes □ No

Are you allergic to cortisone? □ Yes □ No

What goals do you want to accomplish during physical therapy?_____

_____

Patient Signature_____ Date_____