Total Body Rehab

1210 S.E. Maynard Rd. ♦ Suite 103 ♦ Cary, NC 27511 ♦ **919-297-0280 – tel ♦ 919-297-0281 - fax**

Medical History

*To help us meet your healthcare needs, please fill out this form completely on **both sides.***
This is a confidential record of your medical history and will be kept in this office.

Patient Name:_____
Last First M.I.

Today's Date:_____ Date of Birth:_____ Age:_____
Occupation:_____

Current Condition / Chief Complaint:

In detail, describe the reason you are seeking physical therapy:_____
_____
_____
_____
_____

Date of onset:_____ Have you ever had this problem before? yes ❖ no

If "yes" what did you do for the problem?_____
_____
_____
_____Did it get better? yes ❖ no

What makes it feel better?_____
_____
_____

What makes it feel worse?_____
_____
_____

Have you had any X-rays, CAT scans, MRI's or other diagnostic tests for your recent disorder?

If **yes**, please explain the finding as you understand them_____
_____
_____

Medical History:

Please rate your current health status:

□ Excellent □ Good □ Fair □ Poor

Do you exercise beyond normal daily activities and chores? yes ❖ no
If **"yes"** please describe_____
How often?_____

How many alcoholic beverages do you drink per day?
□ 0-1 □ 2-4 □ 5-6 □ 6 or more

Do you currently take any prescription medications? yes ❖ no
If **"yes"** please list:_____
_____

Do you currently take any nonprescription medications? yes ❖ no
If **"yes"** please indicate which ones: □ Aleve/Advil □ Antacids
□ Antihistamine/decongestant □ Aspirin
□ Herbal supplements □ Tylenol
□ Other (please describe):_____

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

□ Arthritis
□ Bone disease / fracture
□ Osteoporosis/osteopenia
□ Circulation problems
□ Pins and Needles
□ Pacemaker
□ High blood pressure
□ Chronic Headaches
□ Diabetes
□ Other allergies
□ Allergy to heat/cold
□ Head injury
□ Multiple sclerosis
□ Muscular dystrophy
□ Seizures/epilepsy
□ Dizziness
□ Development or growth problems
□ Metal implants
□ Symptoms in both arms and/or both legs
□ Recent weight loss
□ Thyroid problems
□ Cancer
□ Bowel/bladder problems
□ Hernia
□ Ulcers / GI problems
□ Depression
□ Previous surgery
□ MVA (date:_____)
□ Other:_____

Is there anything else you think we should know about your general health? Please explain.
_____
_____
_____