Sports Therapy and Rehabilitation Services
Medical History and Information

Patient Name: _____ Date: _____

Date of Onset of Injury or Condition: ___/___/____
Diagnosis/Area of Injury or Condition: _____
Have you had previous therapy for this injury/condition? ☐ Yes ☐ No
If yes, please give dates, length of therapy, and setting in which treatment took place:
Hospital _____
Outpatient Clinic _____
Home Health _____
Has your work status changed because of this condition? ☐ Yes ☐ No
What goals would you like to accomplish through therapy? _____
_____

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list all medications (prescription, over the counter, and supplements) you are currently taking:

Medication	**Dosage/Frequency**	**Medication**	**Dosage/Frequency**

Please list any drug reactions/allergies of which you are aware:
_____
_____

Please describe any injuries for which you have been treated (including fractures, sprains, falls, etc.) and/or any surgeries or other conditions for which you have been hospitalized:
_____
_____
_____

Please indicate any diagnostic tests you have had for this condition:
☐ X-ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ EMG ☐ Myelogram ☐ Other: _____

Please indicate all medical conditions that you have now or have had in the past:

☐ Allergies
☐ Anxiety/Depression
☐ Arthritis
☐ Asthma
☐ Autoimmune Diseases
☐ Bowel or Bladder Problems
☐ Cancer of _____ Date: ___/___/____
☐ Diabetes I or II (please circle)
☐ Dizziness/Fainting
☐ Drug or Alcohol Dependence Problems
☐ Epilepsy
☐ Female Problems
☐ Fibromyalgia
☐ GI Problems
☐ High Blood Pressure
☐ Heart Problems
☐ Hepatitis A B C D E (please circle)
☐ Joint Problems
☐ Kidney Disease
☐ Osteoporosis
☐ Pacemaker
☐ Pins or Metal Implants
☐ Rheumatoid Arthritis
☐ Stroke
☐ Tuberculosis
☐ Vertigo
☐ Visual Impairments
☐ Other _____

Are you currently pregnant or is there a chance you could be pregnant? ☐ Yes ☐ No

Do you use any tobacco products? ☐ Yes, how often? _____ packs/day ☐ No ☐ Previously, length of use: _____