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Health History:

Have you ever had any of the following conditions? Check all that apply.

☐ High blood pressure ☐ Heart condition ☐ Stroke ☐ Osteoporosis

☐ Peripheral Neuropathy ☐ Seizures/epilepsy ☐ Vision problems ☐ Diabetes

☐ Hearing problems ☐ Fainting/dizziness ☐ Emphysema ☐ Frequent or severe headaches

☐ Bowel/bladder problems ☐ Cancer ☐ Arthritis ☐ Asthma ☐ Depression

☐ Other:_____

Are you pregnant?	YES	NO	Due date_____
Do you exercise regularly?	YES	NO	How often?_____
Have you had any falls in the past year?	YES	NO	If so, about how many? _____
Do you have a history of fractures?	YES	NO	Where?_____
Do you smoke?	YES	NO	How much per day?_____
Do you drink alcohol?	YES	NO	How many per week?_____

Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking:

_____

_____

Please list all surgeries including dates:_____

_____

Please list all allergies:_____

Diagnostic Tests: Please check any tests or procedures that have been done for your current condition.

☐ X-rays ☐ MRI ☐ CT scan ☐ Bone scan

☐ EMG ☐ Blood work ☐ Bone density ☐ Ultrasound

☐ Other_____

I give permission to Hands On Healing Physical Therapy, LLC to render treatment as needed.

Patient Name: _____

Patient Signature: _____ Date: _____
(Guardian if under 18)