

Suburban Physical Therapy

Accessibility. Experience. Results.

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FREE SCREENING MEDICAL HISTORY

Name _____ Age _____ Date _____

Reason for Today's Visit: _____

List any allergies you have to drugs, food or other items:

List recent major operations: _____ Year _____

(Female Patients): Are you currently pregnant: (Please Check) Yes No

Have you had any of the following illnesses: (Please Check)

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD/ Lung Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |

Other illnesses: (Please Explain): _____

I authorize the above provider to perform a screening of my current injury or complaint. I understand that the Therapist will perform a series of evaluative tests which may involve range of motion and strength testing of specific body parts and joints. The Therapist may also perform certain manual therapy procedures or movements to evaluate your response and to determine your best course of treatment.

Date	Signature of Patient
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