

Alliant Physical Therapy Group
Patient History

Name: _____ Date: _____

Occupation: _____

DAILY ACTIVITIES AT HOME: _____

DAILY ACTIVITIES AT WORK: _____

GIVE A BRIEF HISTORY OF YOUR INJURY: _____

PAST MEDICAL HISTORY: (previous accident, injuries, traumas, surgeries)

HAVE YOU HAD TREATMENT FOR THIS CONDITION? Yes _____ No _____

If yes, Where? _____

When? _____

HAVE YOU HAD ANY OF THE FOLLOWING? ___ X-Ray ___ MRI ___ EMG ___ Other

If yes, are you aware of the results? _____

PLEASE LIST MEDICATIONS THAT YOU ARE TAKING: _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:

___ Rheumatoid Arthritis ___ High Blood Pressure ___ Heart Trouble: _____

___ Pacemaker ___ Epilepsy ___ Diabetes

___ Pregnancy ___ Asthma ___ Black Outs

___ Visual Disturbances ___ Dizziness ___ Weight Loss (>20 lbs)

___ Headaches ___ Ringing in Ears

Others: _____

WHAT ARE YOUR GOALS OF TREATMENT?: _____

Additional Comments: _____
