bodworks
PHYSICAL THERAPY

Medical History Form

Today's Date__

Patient name: (print) DOB:

Preferred name: (print) Preferred Pronoun:

Check all that apply:

- ☐ Diabetes
- ☐ Seizures
- ☐ Osteopenia
- ☐ Edema
- ☐ Pacemaker
- ☐ Pregnancy – wks
- ☐ Heart Condition
- ☐ Cancer/Tumor
- ☐ Osteoporosis
- ☐ Thyroid Disorder
- ☐ Recent weight loss
- ☐ High Blood Pressure
- ☐ Rheumatoid Arthritis
- ☐ Depression/Anxiety
- ☐ Fibromyalgia
- ☐ Change in bowel/bladder
- ☐ Other
- ☐ Dizziness
- ☐ Osteoarthritis
- ☐ Asthma
- ☐ Latex Allergy
- ☐ Anaphylaxis

List any surgeries you have had: _____

List any medications/supplements you currently take:

What is your primary reason for seeking physical therapy?

Describe your symptoms:

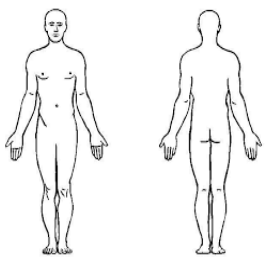
- ☐ Ache
- ☐ Shooting
- ☐ Numbness/tingling
- ☐ Throbbing
- ☐ Dull pain
- ☐ Burning
- ☐ Sharp pain
- ☐ Other

Please rate your pain (0= no pain; 10=worst possible pain)

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate pain — Worst possible pain

Please list the body area(s) where you are experiencing pain:



List any additional health information you would like us to know: