BeneFIT
Physical Therapy

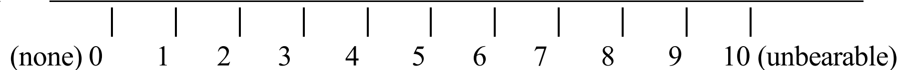
Medical History Form

Name: ___________________________________ DOB:____________________

MEDICAL INFORMATION: TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE/HAVE HAD:

1. High Blood Pressure yes no
2. Chest Pains/Angina/Heart Attack yes no
3. High Cholesterol yes no
4. Pacemaker yes no
5. Shortness of Breath yes no
6. History of Smoking yes no
7. Lung Problems yes no
8. Emphysema/Asthma yes no
9. Bleeding/Bruising yes no
10. Anemia yes no
11. Diabetes yes no
12. Hypoglycemia yes no
13. Lightheadedness/Dizziness yes no
14. Blood Disorders yes no
15. Concussion yes no
16. Fainting Disorders yes no
17. Anxiety/Panic Attacks yes no
18. Arthritis/Joint Pain yes no
19. Artificial Joints yes no
20. Kidney Disease/Stones yes no
21. Hepatitis yes no
22. Spinal Cord Injury yes no
23. Traumatic Brain Injury yes no
24. Fractures: yes no
    Date: _________________Area:_____________
25. Thyroid Problems yes no
26. Polio/Muscle Disease yes no
27. Seizures yes no
28. Chronic/Migraine Headaches yes no
29. TMJ Disorders yes no
30. Chills/Fevers Sweats yes no
31. Swelling of Extremities yes no
32. Sleep Disorders yes no
33. Depression yes no
34. Fibromyalgia yes no
35. Chronic Fatigue Syndrome yes no
36. Lyme's Disease yes no
37. Cancer/Tumors/Growths yes no
38. Are you pregnant? yes no
39. Gynecological Disorders yes no
40. Bladder Incontinence yes no
41. Bowel Incontinence yes no
42. Diarrhea/Nausea/Vomiting yes no
43. Unexplained Weight Loss >10 lbs./last30days yes no
44. UNDER 18 ONLY:
    Immunizations Current yes no

45. Do You Have Any Pain? yes no
    If yes, please list where you have pain:____
    Rate your Pain 0-10



(none) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

CURRENT MEDICATIONS: ____
____

ALLERGIES:
A. To Medications:____
B. To Other Substances:____

SURGERY(S) Include dates:____

What Are Your Fitness Goals? ____

Signature____Date: ____________________________________

Relationship if other than patient/ Parent/ Guardian if Minor____

This information will be used as a guide in your treatment plan. If you need any medical follow-up, please contact your physician.