PhysiGOtherapy
Your Mobile Physio Clinic

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Medical History Form

First Name:_____ **Last Name:**_____

Briefly Describe the history of present illness, injury, accident, or condition:

_____

Date of Onset:_____

List any diagnostic studies *(i.e. CT Scan, MRI, X-ray or other)* **relating to this condition(s):**_____

Location of Diagnostic study_____

Have you been treated for this condition before? ☐ **Yes** ☐ **No**
If Yes, please briefly describe when & the nature of treatment received:

_____

Current Medications *(Prescription/Non Prescription):*_____

List of past surgical procedures & dates:
_____

Do you have METAL anywhere in your body? _____

Please check the following items listed below if they are applicable to you:

High blood pressure		Diabetes *(Type I or Type II)*
High cholesterol		Osteoporosis
Cardiovascular (Heart) Disorders		Arthritis *(osteoarthritis, rheumatoid, psoriatic, autoimmune)*
Circulation Disorder		Pacemaker
Cancer		Seizures
Lung Disorder		Dizzy Spells
Pregnant		Tobacco Use

Have you ever fallen? ☐ **Yes** ☐ **No**
If yes, briefly describe when and cause: _____

Signature:_____ **Date:** _____