Progressive Therapy Services
"a total body approach"

MEDICAL HISTORY

1. **What are you being seen for today?_____**
2. **When was the onset of your symptoms and/or injury:____/_____/_____**
3. **List any precautions or allergies (ie latex, lotions etc.) that could affect your treatment**

   _____

   _____
4. **Are you currently engaged in any form of exercise: _____yes _____no**

If no, please list any limitations: _____

5. **If you are not working due to your injury, when do you anticipate returning to work:___/___/____**
6. **Have you ever been diagnosed by a physician with any of the following:**

☐ **History of cancer** ☐ **Cardiac Disease** ☐ **Respiratory Disease** ☐ **High blood pressure**

☐ **Diabetes** ☐ **Epilepsy** ☐ **Fibromyalgia** ☐ **Myofascial pain**

☐ **Chronic Fatigue** ☐ **Arthritis** ☐ **Osteoporosis** ☐ **Seizures**

☐ **None of the above**

7. **Have you experienced any of the following symptoms in the past two weeks:**

☐ **Dizziness or fainting** ☐ **Illness or fever** ☐ **Nervousness** ☐ **None_____ Initial**

☐ **Unexplained weight loss** ☐ **Abdominal or chest pain** ☐ **Severe fatigue**

8. **Are you pregnant? ____yes ____no**
9. **Please list any medical conditions/surgeries not mentioned above:_____**
10. **Pease list all current medications:_____**
11. **Have you ever been treated by a Physical Therapist for this injury:___yes _____no If yes, please explain:_____**
12. **Are you undergoing or have you undergone any other treatment for this injury?__yes__no**

    If Yes, Please explain: _____
13. **What are your goals for therapy?_____**

_____

Signature Print Name Date