BELDEN
Physical Therapy and Fitness

Patient Medical History

Patient Name (please print)**:** _____

Injury or reason for receiving therapy: _____

_____

Surgery Required? Y N If yes, Date & Type of Surgery: _____

Personal Treatment Goals: (What do you want to accomplish with therapy?): _____

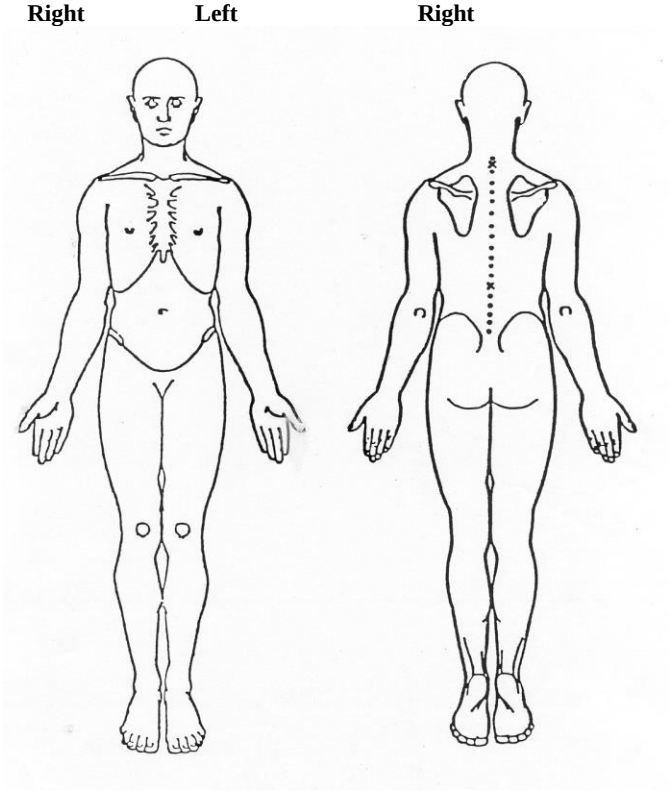
_____

List current physical activities: _____

Conditions: (check all that apply)	History of:	Currently Applies:	Currently Taking Meds for:
Allergies : _____	☐	☐	☐
Arthritis: Osteo / Rheumatoid	☐	☐	☐
Asthma or respiratory problems	☐	☐	☐
Blood disorder, Clotting or Bleeding	☐	☐	☐
Balance Problems, Dizziness, or Falls	☐	☐	☐
Cancer: _____	☐	☐	☐
Circulation Disorders	☐	☐	☐
Depression	☐	☐	☐
Diabetes	☐	☐	☐
Emphysema	☐	☐	☐
Epilepsy / Seizures	☐	☐	☐
Fibromyalgia	☐	☐	☐
Fractures (Broken Bones)	☐	☐	☐
Headaches / Migraines	☐	☐	☐
Head / Brain Injury	☐	☐	☐
Heart Disorders / Abnormal EKG	☐	☐	☐
High Blood Pressure	☐	☐	☐
Hernia: Hiatal / Inguinal	☐	☐	☐
Incontinence of Bowel or Bladder	☐	☐	☐
Infections (Bladder, Ear etc…)	☐	☐	☐
Jaundice / Hepatitis	☐	☐	☐
Kidney Disorder	☐	☐	☐
Lymphedema / Swelling	☐	☐	☐
Neck or Back Pain	☐	☐	☐
Neuromuscular Disorders	☐	☐	☐
Obesity	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Paralysis	☐	☐	☐
Polio or Post-Polio Syndrome	☐	☐	☐
Pregnancy	☐	☐	☐
Psychological Condition	☐	☐	☐
Skin Disorders	☐	☐	☐
Smoking / Tobacco use	☐	☐	☐
Surgery: _____	☐	☐	☐
Stomach / Intestinal Disorders	☐	☐	☐
Stroke	☐	☐	☐
Trauma / Accidents	☐	☐	☐
Visual / Hearing Impairments	☐	☐	☐
Weight Loss / Gain: _____lbs.	☐	☐	☐

Please mark location of injury or affected area(s)

Right **Left** **Right**



Current Pain level: (circle one)

0 1 2 3 4 5 6 7 8 9 10

No pain Max pain

Pain Description: (check all that apply)

☐ Constant ☐ Sharp ☐ Day time

☐ Intermittent ☐ Dull ☐ Night time

☐ Achy

Medication or Supplements (please list any that you are taking): _____

_____

Signature: _____ Date:_____