Care IN MOTION
PHYSICAL THERAPY

Medical History Form

Patient Name_____Date of Birth_____

Past Medical History:
(please check all that apply)

- Hypertension
- Diabetes
- Pacemaker
- Cancer
- Osteoporosis
- Cardiac Disease
- Osteoarthritis
- Shortness of Breath
- COPD
- Asthma
- Kidney disease
- Brain injury
- Stroke
- Multiple Sclerosis
- Rheumatoid Arthritis
- Seizure disorder
- Artificial joint replacement
- Pacemaker
- Light-headed/Dizzy
- Other_____

Other_____
_____
_____

Allergies_____
_____

Medications_____
_____
_____

Surgeries_____
_____

Pain Level 0-10_____Location_____

Patient Signature_____

Physical Therapist Signature_____