PHYSICAL THERAPY Cascade

Patient Medical History

Do you now have or have ever had any of the following:

	Yes	No		Yes	No		Yes	No
Diabetes	❑	❑	Cancer	❑	❑	Allergy to Heat and Ice	❑	❑
Heart Disease	❑	❑	Stroke/TIA	❑	❑	Other Allergies	❑	❑
Heart Attack	❑	❑	Dizziness or Fainting	❑	❑	Kidney Disorder	❑	❑
High Blood Pressure	❑	❑	Anxiety/Nervous Disorder	❑	❑	Hernia	❑	❑
Asthma, Bronchitis or Emphysema	❑	❑	Severe or Frequent Headaches	❑	❑	Epilepsy/Seizures	❑	❑
Pacemaker	❑	❑	History of Blood Clots	❑	❑	Metal Implants	❑	❑
Congestive Heart Disease	❑	❑	Osteoporosis	❑	❑	Previous Surgery	❑	❑
Shortness of Breath/ Chest Pain	❑	❑	Arthritis	❑	❑	Are you pregnant?	❑	❑

If yes to any of the above, please explain and give approximate dates:

_____

_____

Are you currently taking medication? ❑Yes ❑No

If yes, please list what medication and for what condition?

_____

_____

_____

Have you had previous PHYSICAL THERAPY for your present condition? ❑Yes ❑No

_____

Have you received any other Therapy Services in this calendar year? ❑Yes ❑No

Have you received or are you currently receiving Home Health Therapy? ❑Yes ❑No

Have you had diagnostic testing (MRI, CT scan, x-rays) for your current condition? ❑Yes ❑No

If yes, state where and when testing was performed:

_____

_____

Injury Information:

Date of Injury/Onset:_____ Date of Surgery:_____

Address where injury took place and how injury happened: _____

_____

Is this a work-related injury or condition? ❑Yes ❑No Claim#_____

Worker's Compensation Carrier_____ Adjustor_____

Address_____ Phone#_____

_____

Is this the result of a motor vehicle accident? ❑ Yes ❑ No Is there a lawsuit pending? ❑Yes ❑ No

Attorney_____Address_____Phone#_____

_____

Patient or Guardian Signature:_____ Date:_____