PURE SPORTS
Physical Therapy

Medical History Form and Systems Review

What is the reason for your visit today? _____
How did your pain begin? _____
Date of Onset/Injury: _____Date of Surgery: _____
Type of Surgery: _____

Have you had any treatments or are you currently seeing any of the following for your current injury?

☐Physical Therapist
☐Medical Doctor
☐Chiropractor
☐Psychiatrist/Psychologist
☐Osteopath
☐Masseuse

Have any diagnostic tests have been performed for this injury?
☐X-rays ☐MRI ☐EMG ☐CT Scan ☐Other_____

Have you had similar symptoms in the past? _____
Are you currently taking any prescription or non-prescription medication? If so, please list them: _____
_____

Do you smoke? ☐YES ☐NO Are you pregnant? ☐YES ☐NO

Please check all that apply:

☐Cancer
☐Heart Conditions
☐Diabetes
☐High Blood Pressure
☐Stroke/TIA
☐Rheumatoid Arthritis
☐Osteoarthritis
☐Parkinson's
☐Polymyalgia
☐Multiple Sclerosis
☐Lupus
☐Epilepsy/Seizures
☐Fibromyalgia
☐Chronic Fatigue
☐Numbness/Tingling
☐Osteoporosis
☐Headaches/Migraines
☐Bulging Disks
☐Tuberculosis
☐Skin Allergies/Rashes
☐Hepatitis
☐Weakness in your legs
☐Bowel or bladder troubles
☐Blurred vision or nausea
☐Dizziness with neck mov't
☐Other

Please list any other prior injuries, broken bones or surgeries with approximate dates: _____
_____