Name: Date:

Medical History

Allergies	Yes O	No O		**Gallbladder Problems**	Yes O	No O	
Anemia	Yes O	No O		**Hepatitis**	Yes O	No O	
Anxiety	Yes O	No O		**High Blood Pressure**	Yes O	No O	
Arthritis	Yes O	No O		**Incontinence**	Yes O	No O	
Asthma	Yes O	No O		**Kidney Problems**	Yes O	No O	
Cancer	Yes O	No O		**Metal Implants**	Yes O	No O	
Cardiac Conditions	Yes O	No O		**Multiple Sclerosis**	Yes O	No O	
Cardiac Pacemaker	Yes O	No O		**Osteoporosis**	Yes O	No O	
Chemical Dependency	Yes O	No O		**Parkinsons**	Yes O	No O	
Circulation Problems	Yes O	No O		**Rheumatoid Arthritis**	Yes O	No O	
Currently Pregnant	Yes O	No O		**Seizures**	Yes O	No O	
Depression	Yes O	No O		**Speech Problems**	Yes O	No O	
Diabetes	Yes O	No O		**Strokes**	Yes O	No O	
Dizzy Spells	Yes O	No O		**Thyroid Disease**	Yes O	No O	
Emphysema/Bronchitis	Yes O	No O		**Tuberculosis**	Yes O	No O	
Fractures	Yes O	No O		**Vision Problems**	Yes O	No O	
				Sexually Transmitted Diseases or/ AIDS	Yes O	No O	

Fall History

Injury as a result of a fall in the past year? Yes O No O

Two or more falls in the last year? Yes O No O

Surgical History (If needed - please turn over and add to back.)

Body Region:_____ Surgery Type:_____ Month/Year:_____

Body Region:_____ Surgery Type:_____ Month/Year:_____

Body Region:_____ Surgery Type:_____ Month/Year:_____

Body Region:_____ Surgery Type:_____ Month/Year:_____

Current Medications (If needed - please turn over and add to back.)

Drug: _____ Dosage:_____ Reason Taking:_____

Drug: _____ Dosage:_____ Reason Taking:_____

Drug: _____ Dosage:_____ Reason Taking:_____

Drug: _____ Dosage:_____ Reason Taking:_____

Drug: _____ Dosage:_____ Reason Taking:_____

Drug: _____ Dosage:_____ Reason Taking:_____

Drug: _____ Dosage:_____ Reason Taking:_____

Drug: _____ Dosage:_____ Reason Taking:_____

What is your occupation:_____

Please explain your job duties:_____

_____

In what physical activities/hobbies to you participate and how often?_____

_____

_____

What is your goal for coming to therapy?_____

BROOKSIDE PHYSICAL THERAPY, P.C.

8859 Fox Drive • Suite 300 • Thornton, Colorado 80260-6831
(303) 428-4646 • Fax (303) 429-6255

SUE MOORE, MS, PT, MTC

EMERGENCY CONTACT INFORMATION

Name: _____

Emergency Contact: _____
Phone Number: _____
Relationship to patient: _____

Emergency Contact: _____
Phone Number: _____
Relationship to patient: _____