

## JOINT EFFORT REHAB LLC MEDICAL HISTORY

**A complete medical history is necessary for a thorough evaluation. Please answer the following questions:**

Your Name:				Date:
Date of Birth:	Age:	Height:	Weight:	Do you Smoke?:      No      Yes

**Have you ever been diagnosed with any of the following?**

Tuberculosis	No	Yes	Epilepsy	No	Yes
Hepatitis	No	Yes	Arthritis	No	Yes
Diabetes	No	Yes	Heart Condition	No	Yes
Stroke	No	Yes	Cancer	No	Yes
Chronic Respiratory Problems	No	Yes	Asthma	No	Yes
Are you currently pregnant?	No	Yes	Closed Head Injury	No	Yes

**Have you received any injections for your injury or condition?**                      No      Yes

If yes, what kind and when? \_\_\_\_\_

Did it help?              No      Yes

**Are you exercising?**              No      Yes      Describe \_\_\_\_\_

**Problems with exercise?**              No      Yes      Describe \_\_\_\_\_

**What do you hope to accomplish with physical therapy?** \_\_\_\_\_

**Significant past or present medical diagnoses and chronic conditions not listed above:**

Diagnosis	Physician	Medications

**Is there any other pertinent information you would like us to know about your condition?**

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