A.U.M. Physical Therapy & Wellness Center

The Comfort of Exceptional Care

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICAL HISTORY:

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

DESCRIBE ANY OTHER CONDITIONS OR PRECAUTIONS:

FALLS HISTORY:

Injury as a result of a fall in the past year: O Yes O No Date Of Fall: _____

Two of more falls in the last year: O Yes O No Dates Of Fall: _____

SURGICAL HISTORY:

Body Region: _____ Surgery Type: _____ Date Of Surgery: _____

Body Region: _____ Surgery Type: _____ Date Of Surgery: _____

Body Region: _____ Surgery Type: _____ Date Of Surgery: _____

Body Region: _____ Surgery Type: _____ Date Of Surgery: _____

Body Region: _____ Surgery Type: _____ Date Of Surgery: _____

CURRENT MEDICATION:

Drug: _____ Dosage: _____ Reason For Taking: _____

Drug: _____ Dosage: _____ Reason For Taking: _____

Drug: _____ Dosage: _____ Reason For Taking: _____

Drug: _____ Dosage: _____ Reason For Taking: _____

Drug: _____ Dosage: _____ Reason For Taking: _____

Drug: _____ Dosage: _____ Reason For Taking: _____

Drug: _____ Dosage: _____ Reason For Taking: _____

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Comprehensive Physical and Occupational Therapy Services

1065 Andrew Drive Suite B-3 West Chester, PA 19380 Telephone: 610.344.7374 Fax: 610.344.7530

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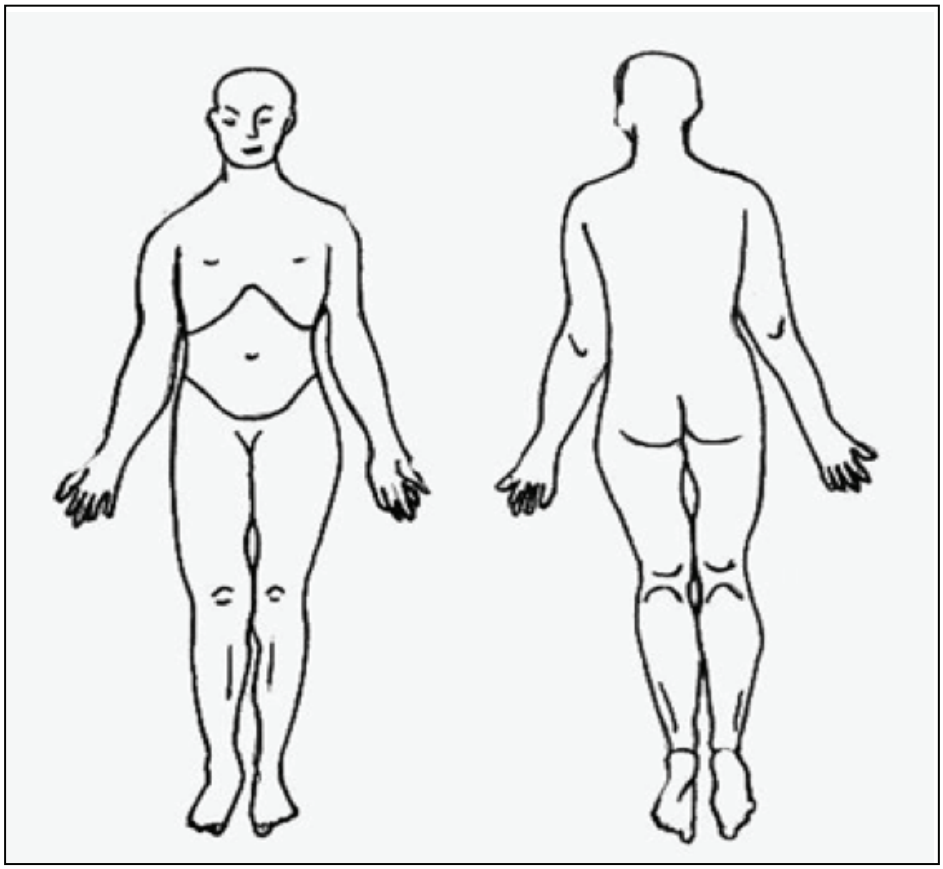
When did your illness/injury occur? _____

On a scale from 0 (*No pain*) to 10 (*Severe*) how much pain do you have now?

0 1 2 3 4 5 6 7 8 9 10

Please use the picture where your pain is:

*	Pain	X	Numbness/tingling	///	Radiating pain



Height _____' _____"

Weight _____lbs

_____

Patient's Signature: _____Date:_____

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