Medical History Information

Name:_______________________________________ DOB:__________________________

Address:____________________________ City:________________________________

State:______ Zip:_________ Phone #:________________ Text Reminders ok? Y N

Is your above address also your billing address for credit card on file? Yes No

Do you have **Medicare** coverage for your health insurance? Yes No

COVID-19 Vaccination? Yes No Date of last vaccination shot? ______________________

Booster? Yes No Date of Booster shot?_________________

Email:____

Emergency Contact Name:___________________________ Phone #:__________________

Relationship to you:________________________________

Occupation (past or present):____

How were you referred/recommended to us:____

Primary Physician: ________________________________ Phone #:__________________

Specialist Physician:________________________________ Phone #:__________________

Did you inform your physician that you are starting Physical Therapy and/or Pilates? Yes No

Have you had any change in health status over the last 12 months? Please include any **injuries, surgeries, new diagnoses or new medication.**

____
____
____

Please list all supplements, over the counter and prescription medications that you are taking:

1.____________________ 2.___________________ 3.____________________
4.____________________ 5.___________________ 6.____________________
7.____________________ 8.___________________ 9.____________________

Women: Are you (or could you be) pregnant?   Yes   No

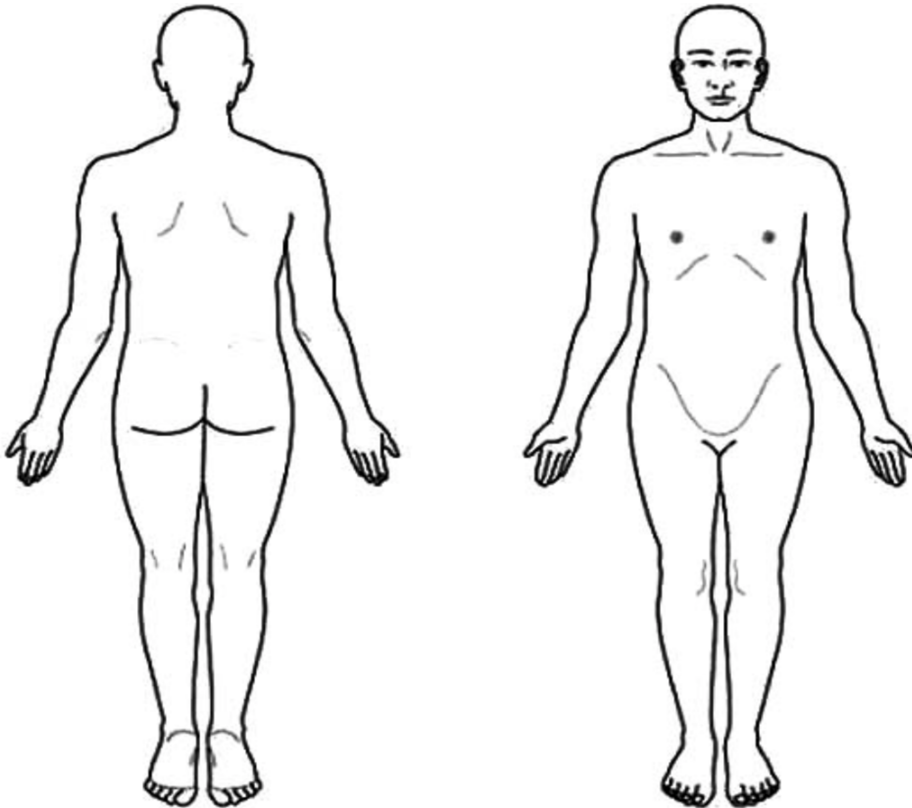
Number of pregnancies:______   Vaginal or Cesarean delivery (circle)

Have you or any immediate family member (parent, sibling, child) been told you have (circle):

Allergies	Depression	Liver Disease
Arthritis	Diabetes	Osteoporosis/Osteopenia
Asthma	Eating Disorder	Shortness of Breath
Cancer	Heart Problems	Skin Problems
Chemical Dependency (alcohol/drugs)	High Blood Pressure	Stroke
	Joint Replacement	Thyroid Problems
Circulation Issues	Kidney Disease	Varicose Veins

If any are circled, please explain:____

Please mark any areas of symptoms in your body



On a scale of 1-10, what is your current pain level?_______   Best:________   Worst:________

My signature gives my consent to be treated. I understand that I always have a right to refuse treatment and/or ask questions for any reason if I am uncomfortable with the options recommended.

______________________________   ____________________________________   ______________________

Patient/Client name (print) (or parent if minor)   Signature   Date