Medical History Information

Name:_____ DOB:_____ Age: _____

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

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

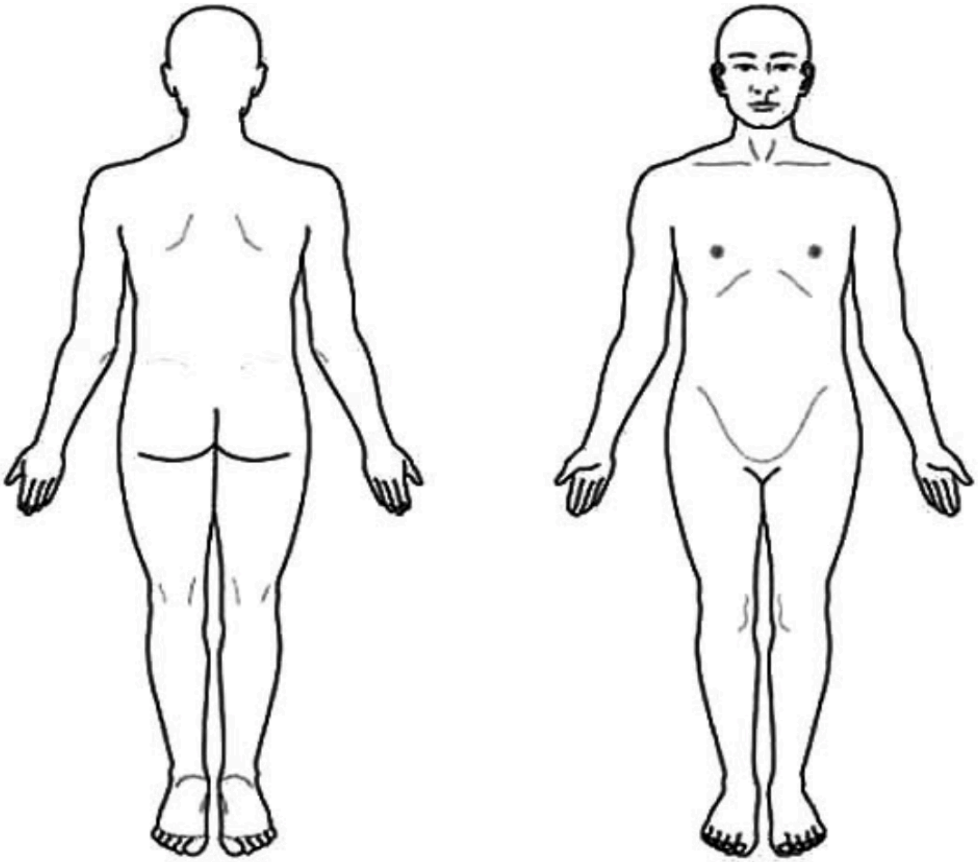
Number of pregnancies:_____ Vaginal or Cesarean delivery (circle)

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	High Blood Pressure	Stroke
(alcohol/drugs)	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