Name: _____ **DOB**_____ *The Physical Therapy Clinic, Inc.* **dba Axis Physical Therapy**

Allergies	○ Yes	○ No	Diabetes	○ Yes	○ No	Metal Implants	○ Yes	○ No
Anemia	○ Yes	○ No	Dizzy Spells	○ Yes	○ No	MRSA	○ Yes	○ No
Anxiety	○ Yes	○ No	Emphysema/Bronchitis	○ Yes	○ No	Multiple Sclerosis	○ Yes	○ No
Arthritis	○ Yes	○ No	Fibromyalgia	○ Yes	○ No	Muscle Disease	○ Yes	○ No
Asthma	○ Yes	○ No	Fractures	○ Yes	○ No	Osteoporosis	○ Yes	○ No
Autoimmune Disorder	○ Yes	○ No	Gallbladder Problems	○ Yes	○ No	Parkinsons	○ Yes	○ No
Cancer	○ Yes	○ No	Headaches	○ Yes	○ No	Rheumatoid Arthritis	○ Yes	○ No
Cardiac Conditions	○ Yes	○ No	Hearing Impairment	○ Yes	○ No	Seizures	○ Yes	○ No
Cardiac Pacemaker	○ Yes	○ No	Hepatitis	○ Yes	○ No	Smoking	○ Yes	○ No
Chemical Dependency	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Speech Problems	○ Yes	○ No
Circulation Problems	○ Yes	○ No	High/Low Blood Pressure	○ Yes	○ No	Strokes	○ Yes	○ No
Covid-19	○ Yes	○ No	HIV/AIDS	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Currently Pregnant	○ Yes	○ No	Incontinence	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Depression	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Vision Problems	○ Yes	○ No

Describe any other conditions or precautions (including PTSD):

PAIN NOW: _____ Scale 0-10

PAIN at Worst: _____ Scale 0-10

PAIN at Best: _____ Scale 0-10

10 = Emergency Room, 0 = no pain

Fall History

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

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

****Have you received the Covid-19 "Vaccine"?** ○ Yes ○ No

If Yes, date(s): _____ Version: _____

Surgical History : Body Region: Surgery Type: Surgery Date: (MONTH and YEAR)

Current Medications: **If you have a list, please let us copy!**

Drug:	Frequency:	Route:	Reason Taking:

Signature of Patient: _____ Date: _____