

Name: _____ DOB _____

The Physical Therapy Clinic, Inc. dba Axis Physical Therapy

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

Describe any other conditions or Precautions:

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

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: _____