GLACIER PEAKS
mobile physical therapy

Patient Medical History Form

It is your obligation to provide full disclosure of your past medical history that may impact, influence or contraindicate the prescribed service provided by GPMPT.

First name _____ Last name _____ DOB: ___ ___ _____

Mailing address _____

Primary care provider _____

Referring physician _____

Date of referring physician visit for injury _____

Do you now or have you ever had any of the following?

	Y		Y
Allergies		High Blood Pressure	
To what?		HIV/AIDS	
Anemia		Incontinence	
Amputation		Menopause	
To what?		Numbness or Tingling	
Anxiety or Depression		Where?	
Asthma, Bronchitis, or Emphysema		Osteoarthritis	
Autoimmune Disorder		Osteoporosis	
What kind?		Pacemaker	
Blood Clot/Embolism		Parkinson's Disease	
Bowel or Bladder Problems		Are you currently pregnant?	
Cancer		Number of pregnancies	
What kind?		Number of births	
Coronary Heart Disease or Angina		Rheumatoid Arthritis	
Diabetes		Shortness of Breath/Chest Pain	
Dementia		Do you smoke?	
Dizziness or Fainting		Spinal cord injury	
Epilepsy/Seizures		Stroke/TIA	
Fibromyalgia		Varicose Veins	
Gout		Vision or Hearing Difficulties	
Heart Attack or Heart Surgery		Weakness	
Hepatitis B/C		Weight Loss/Energy Loss	
Hernia			

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If you answered "Yes" in response to any of the questions on the previous page, please provide more detailed information as to each condition or event for which you answered "Yes" for purposes of discussion with your Physical Therapist. Your description of your condition and care and treatment you may have received will assist us in providing appropriate care to you. If you need additional space to answer, please tell your Physical Therapist.

Surgical history: _____

Are you aware of a diagnosis that has led you to seek Physical Therapy with Glacier Peaks Mobile Physical Therapy? Y ☐ N ☐

What are your expectations and goals for Physical Therapy with GPMPT?

By my signature below, I hereby certify and attest that the medical history information I have provided is complete, accurate and truthful to the best of my knowledge.

Patient Name (Print) _____

Patient Signature _____ Date _____

Name of Authorized Legal Representative of Patient (If Applicable)

Name (Print) _____

Signature _____ Date _____