Medical History Form

excel therapy
PHYSICAL THERAPY & SPORTS MEDICINE

Please fill out any patient information below. Then print and bring the hard copy with you to your appointment.

1. Date of current injury:
2. Are you off work due to your injury? YES ◯ NO ◯
3. If you are not off work, are you on restricted duty? YES ◯ NO ◯
4. Date of current surgery if applicable:
5. Other surgeries related to current problem:
6. Have you had previous treatment for your injury? YES ◯ NO ◯ Describe:
7. Are you currently seeing a chiropractor for your injury? YES ◯ NO ◯
8. Do you have a pacemaker? YES ◯ NO ◯ If no, do you have another heart rhythm problem?
   Do you take medication for this heart problem? YES ◯ NO ◯ If yes, what type?
9. Have you had a recent weight gain or loss? YES ◯ NO ◯
10. Do you have a history of cancer? YES ◯ NO ◯ If yes, what type?
11. Do you have a family history of cancer? YES ◯ NO ◯
12. What medication have you been prescribed for your current injury?
13. Are you currently pregnant? YES ◯ NO ◯ N/A ◯ If yes, how many months?
14. Select all the apply to you.

- ☐ Heart Problems
- ☐ Lung Disease
- ☐ Asthma
- ☐ Hearing Loss
- ☐ Diabetes
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Osteoarthritis
- ☐ Epilepsy
- ☐ Eye Disease
- ☐ Tuberculosis
- ☐ Circulation Problems
- ☐ Stroke
- ☐ Rheumatoid Arthritis
- ☐ Chemical Dependency
- ☐ Multiple Sclerosis
- ☐ Hepatitis
- ☐ Osteoporosis

→ Please make sure your physician and pharmacist are aware of any over the counter medicine you take including vitamins and supplements.

→ If you smoke, please understand that the chemicals in tobacco affect circulation which, in turn, can have an adverse affect on the healing process.

→ Proper nutrition is important to both injury prevention and recovery from an injury. If you would like nutritional consultation, please ask your therapist for help in identifying a local dietitian.

PAITENT NAME (PRINTED) SIGNATURE DATE