MONTCLAIR PHYSICAL THERAPY INC.

ACTIVE METHOD PHYSICAL THERAPY

GET AMPT · BE STRONG

# MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

LEGAL NAME: _____ PREFERRED NAME:_____

DOB:_____ PREFERRED PRONOUNS (circle): he/him she/her they/them Other: _____

HEIGHT:_____ ft. _____in. WEIGHT:_____ lbs. OCCUPATION:_____

**ALLERGIES:** List any medication(s) you are allergic to: _____

Are you latex sensitive? ☐ Yes ☐ No Any other relevant allergies: _____

**Do you have:**

| | | |
|---|---|---|
| **METAL in your body? (other than teeth)** | ☐ Yes | ☐ No |
| **A pacemaker?** | ☐ Yes | ☐ No |
| **Abnormal vision problems?** | ☐ Yes | ☐ No |
| **Abnormal hearing problems?** | ☐ Yes | ☐ No |
| **Unusual weight gain or loss lately?** | ☐ Yes | ☐ No |
| **Recent loss of bowel or bladder control?** | ☐ Yes | ☐ No |

**Have you EVER been diagnosed with:**

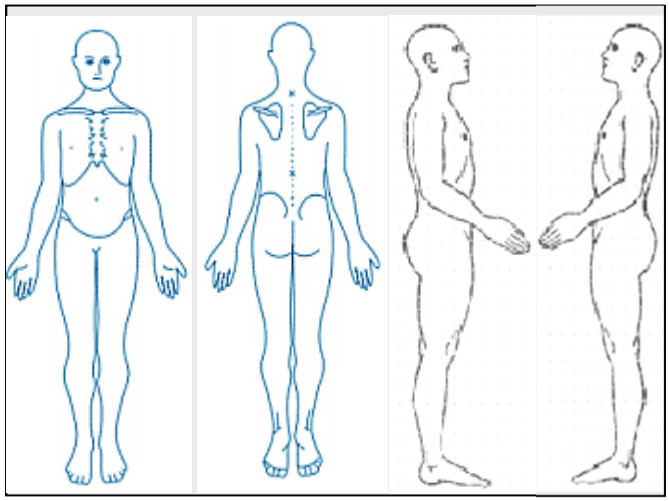
☐ Arthritic conditions
☐ Asthma
☐ Blood clots
☐ Circulation problems
☐ Depression
☐ Diabetes
☐ Hepatitis
☐ Seizures
☐ High blood pressure
☐ Immune Deficiency Disease
☐ Multiple sclerosis
☐ Osteoporosis
☐ Rheumatoid arthritis
☐ Stomach ulcers
☐ Stroke
☐ Thyroid problems
☐ Tuberculosis
☐ Cancer. If YES what kind: _____
☐ Chemical dependency (i.e., alcoholism) _____
☐ Heart Problems. If YES what kind_____
☐ Kidney disease If YES what kind_____
☐ Other diagnoses:_____

**Which of the following medications have you taken in the last week?** ☐ Aspirin ☐ Tylenol ☐ Herbals/Remedies
☐ Stomach ulcer medication ☐ Vitamins/Supplements
☐ Anti-inflammatories (Advil/Motrin/Ibuprofen etc)
☐ Others NOT prescribed by a physician _____

**Please provide list of any other physician-prescribed medications you are currently taking (INCLUDE: name of drug, dosage, frequency, and administered route):** _____

_____

**Please mark where you have pain.**



**Please provide a brief summary of your injury:**

_____

_____

_____

_____

**For your current condition, have you received any of the following?** ☐ **Xray(s)** ☐ **CT scan** ☐ **MRI**

**Have you ever had any surgeries?** ☐ Yes ☐ No
**If yes, please list the surgeries including the approximate date:** _____

_____

_____

**(For women only) Are you pregnant?** ☐ Yes ☐ No
**If yes, how many weeks?**_____

_____ _____ _____
Therapist Signature Client Name (Please print) Date

_____ _____ _____
Guardian Signature Date Client Signature