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	N		Y	N
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		
Dimentia			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 _____