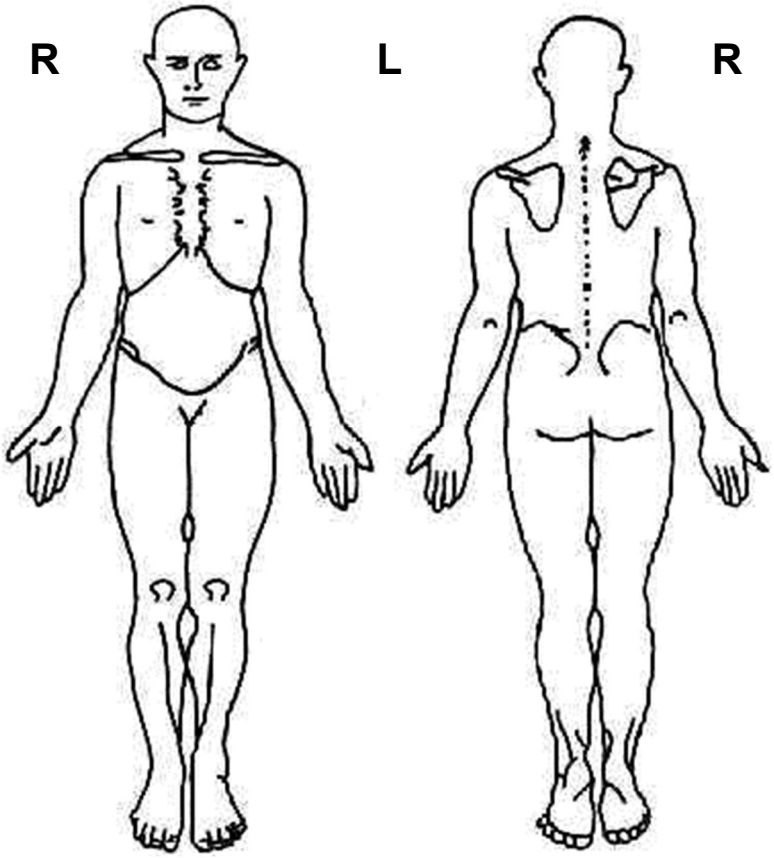
Capitol Physical Therapy

Medical History

Please use the body chart to identify the symptoms that you are being seen for:

XXX: Numbness/tingling
////////: Sharp pain
OOO: Burning pain
====: Dull Ache
******: Stiffness/tension



Name: _____

Date of Birth: _____

Height: _____

Weight: _____

Please provide your relevant surgical history, including type of procedure and approximate year:

Please describe any previous treatments you have had for the condition we are seeing you for:
(including medications, injections, therapies, chiropractic work, acupuncture, etc.)

Please list any relevant current injuries/conditions you have, other than what we are seeing you for:

Please mark if you currently have, or have ever had, any of the following:

___ Allergies (non-seasonal) ___ Asthma ___ Cancer ___ Circulation Problems

___Diabetes ___ Dizziness ___ Frequent Headaches ___ Heart Problems

___ Nervous Disorders ___ Pacemaker ___ Respiratory Problems ___ Seizures

Please offer additional clarification, including approximate years where appropriate, for anything marked above: _____

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