PHYSICAL THERAPY ASSOCIATES OF MERCER COUNTY, P.C.

PATIENT MEDICAL INFORMATION FORM

Name_____Occupation_____Age_____

Current Complaint_____

Date of onset of: injury/surgery/problem_____

Briefly State Previous Treatment, if any:_____

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

Diabetes	yes__no__	Allergy to Cold	yes__no__
High Blood Pressure	yes__no__	Other Allergies	yes__no__
Pacemaker	yes__no__	Previous Surgery	yes__no__
Chronic Headaches	yes__no__	Seizures	yes__no__
Kidney Problems	yes__no__	Metal Implants	yes__no__
Nervous Disorders	yes__no__	Dizziness	yes__no__
Hernia	yes__no__	Cancer	yes__no__
Allergy to Heat	yes__no__	Pregnant	yes__no__
Bone Disease/Fractures	yes__no__	Osteoporosis	yes__no__
Bowel/Bladder Problems	yes__no__	Recent Weight Change	yes__no__
Pins and Needles	yes__no__	Symptoms in both	
Circulatory Disease	yes__no__	arms and/or legs	yes__no__

If yes to any of the above, please explain and give appropriate details:

Are you presently taking any medications? Yes__No__ If yes, please list what medications and for what conditions(s):

Have you had any X-rays, CAT scans, MRIs, or other diagnostic test for your recent disorder? Yes__No__ If yes, please explain the findings as you understand them

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Is there anything else you think we should know about your general health? Please explain and if necessary, we can talk about it

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Is there anyone that you do not authorize this information to be released to as it pertains to your treatment? If so, please give their name(s)