Biosports
PHYSICAL THERAPY

MEDICAL HISTORY

Name _____ Birthdate _____

Medical Doctor _____

Have you been under the care of a physician during the past two years?	Yes	No
If female, are you now pregnant?	Yes	No
Do you exercise? How many days per week? _____	Yes	No
Do you smoke?	Yes	No
Have you been hospitalized or had any surgery in the last five years?	Yes	No
Have you had any other serious illness?	Yes	No

Please summarize your past medical history by checking all that apply

- ☐ Addiction
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Cancer
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic pain
- ☐ Heart disease
- ☐ Hearing impairment
- ☐ Hypertension
- ☐ Insulin dependent diabetes mellitus
- ☐ Low vision
- ☐ Mental Health Concerns
- ☐ Non-insulin dependent diabetes mellitus
- ☐ Nutritional/Hydration concerns
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatic disease
- ☐ Other _____

I hereby grant permission for Physical Therapy to be performed on myself or this minor and will assume all responsibilities connected with such treatment.

Signature _____ Date _____
(Patient/Parent or Guardian of Minor)

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