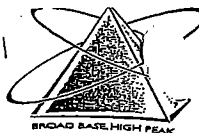
BIOSPORTS
IOMECHANICAL SPORTS THERAPY, P.C.
18 NORTH WORTHEN SUITE 200
WENATCHEE, WASHINGTON 98801



MEDICAL HISTORY

Name ______________________ Birthdate ______________________

Medical Doctor ______________________

Have you been under the care of your physician during the past two years? Yes No

If female, are you now pregnant? Yes No

Do you exercise? Yes No

How many days per week? ________

Do you smoke? Yes No

Please list medications that you are currently taking

1) ______________________ 2) ______________________

3) ______________________ 4) ______________________

Please summarize your past medical history by checking all that apply

- ☐ Addiction
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Autism
- ☐ Brain injury/Concussion
- ☐ Cancer
- ☐ Cardiac Issues
- ☐ Cardiovascular Disease
- ☐ Cerebral Palsy
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic pain
- ☐ Cystic Fibrosis
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart disease
- ☐ Environmental Exposure
- ☐ Mental Health Concerns
- ☐ Medical Surgeries
- ☐ Orthopedic Surgeries
- ☐ Hypertension
- ☐ Insulin Dependent Diabetes
- ☐ Low Vision
- ☐ Meningitis
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Non-insulin dependent diabetes mellitus
- ☐ Nutritional/Hydration concerns
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Recurrent Strep
- ☐ Rheumatic disease
- ☐ Seizures
- ☐ Sensory Processing Disorder
- ☐ 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)