MEDICAL HISTORY

Name _____ Birthdate _____

Medical Doctor _____

Please list the 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
- ☐ Cardiovascular Disease
- ☐ Cerebral Palsy
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Chronic pain
- ☐ Cystic Fibrosis
- ☐ Headaches
- ☐ Hearing impairment
- ☐ Environmental Exposure
- ☐ Mental Health Concerns_____
- ☐ Other _____
- ☐ Medical Surgeries _____
- ☐ Orthopedic Surgeries_____
- ☐ Hypertension
- ☐ Insulin dependent diabetes mellitus
- ☐ 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

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)