INNOVATIVE PHYSICAL THERAPY SOLUTIONS, PC
316 Sherman Street • Watertown, NY 13601-3614
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Medical History

Date: _____/_____/_____

Name:_____ Date of Birth: _____/_____/_____

If you have ever had a listed condition in the past or are presently troubled, please check it in the YES column. The information you provide concerning past and present conditions and diseases assist your therapist in more thoroughly understanding your state of health.

Condition:	Yes	No	Condition:	Yes	No
Allergies	☐	☐	Hepatitis	☐	☐
Anemia	☐	☐	High Cholesterol	☐	☐
Anxiety	☐	☐	High/Low Blood Pressure	☐	☐
Arthritis	☐	☐	HIV/AIDS	☐	☐
Asthma	☐	☐	Incontinence	☐	☐
Autoimmune Disorders	☐	☐	Kidney Problems	☐	☐
Cancer	☐	☐	Metal Implants	☐	☐
Cardiac Disorders	☐	☐	MRSA	☐	☐
Cardiac Pacemaker	☐	☐	Multiple Sclerosis	☐	☐
Chemical Dependency	☐	☐	Muscular Disease	☐	☐
Circulation Problems	☐	☐	Osteoporosis	☐	☐
Currently Pregnant	☐	☐	Parkinsons	☐	☐
Depression	☐	☐	Rheumatoid Arthritis	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Dizzy Spells	☐	☐	Smoking	☐	☐
Emphysema/Bronchitis	☐	☐	Speech Problems	☐	☐
Fibromyalgia	☐	☐	Strokes	☐	☐
Fractures	☐	☐	Thyroid Disease	☐	☐
Gallbladder Problems	☐	☐	Tuberculosis	☐	☐
Headaches	☐	☐	Vision Problems	☐	☐
Hearing Impairment	☐	☐			

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions:

_____
_____
_____

Current Height and Weight:

Ht:____'____" Wt:_____lbs

Fall History	Yes	No
Injury as a result of a fall in the past year?	☐	☐
Two or more falls in the last year?	☐	☐
Are you at risk for falls?	☐	☐

Surgical History (Including body region, surgery type and approximate dates)

_____
_____
_____

Current Medications (Including drug, dosage, frequency, route, and reason for taking)

_____
_____
_____

I certify that, to the best of my knowledge and belief, the statements provided here are true and correct.

_____

Patient/Guardian Signature Date