BEND & STRETCH
Pilates | Physical Therapy
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MEDICAL HISTORY

Name: (First) _____ (Middle Initial) _____

(Last) _____

Prescription Medications / Supplements: _____

Allergies: _____

Surgeries: _____

_____

CURRENT SYMPTOMS: (Check all that apply)

- ○ Chest Pain
- ○ Coordination Problems
- ○ Decreased range of motion in : _____
- ○ Difficulty concentrating
- ○ Difficulty sleeping
- ○ Headaches
- ○ Hearing Problems
- ○ Loss of balance
- ○ Pain at night
- ○ Loss of bowel control/incontinence
- ○ Headaches
- ○ Numbness/tingling at: _____
- ○ Dizziness
- ○ Visual problems
- ○ Weakness in: _____
- ○ Arthritis in: _____
- ○ High Blood Pressure
- ○ Other (major illness/recurrent issue) _____
- ○ Head injury/trauma
- ○ Broken bones _____
- ○ Circulation problems
- ○ Lung problems
- ○ Depression
- ○ Parkinson's disease
- ○ Thyroid conditions
- ○ Kidney problems
- ○ Osteoporosis
- ○ Heart Problems
- ○ Stroke
- ○ Heart Attack
- ○ Low blood sugar/hypoglycemia
- ○ Seizures/Epilepsy
- ○ Skin Disorders
- ○ Infections disease (HIV, TB, Hep C, etc)
- ○ Diabetes Type: _____
- ○ Cancer: _____

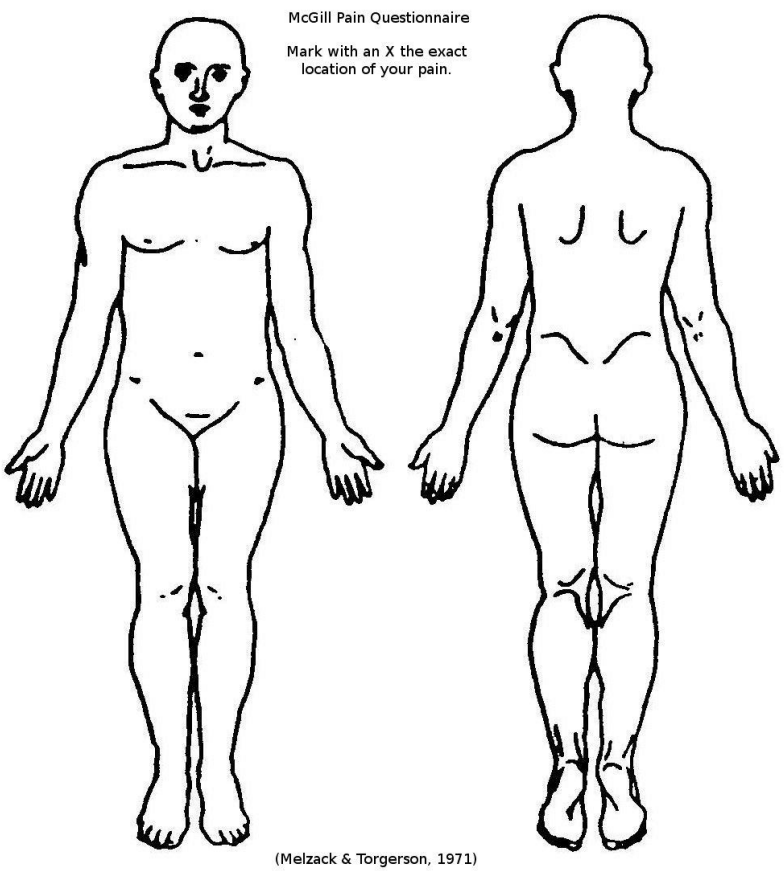
What brings you to therapy today? _____

When did your symptoms begin? _____

On a scale 0 to 10, with zero being "no pain" and 10 being "the most excruciating pain possible", please indicate your pain level today: _____ at best over the past week: _____ at worst over the past week: _____

What makes your symptoms WORSE: _____

What makes your symptoms BETTER:_____



Smoking? ____ Yes ____ No

Have you had any previous treatment for your current condition? (acupuncture, chiropractic, PT, Massage, etc)_____

_____

_____

Have you had any diagnostic imaging studies (x-rays, MRI, CT Scans, US…..)? _____

_____

What do you do for physical activity/exercise? _____

How many hours/week? _____

What are your recreational activities/hobbies? _____

_____

What are your goals for Physical Therapy?

1. _____
2. _____
3. _____

Patient: _____ Date: _____

Parent/Guardian (if patient is under age of 18) _____ Date: _____