

MALETTA PFEIFFER & ASSOCIATES, L.L.C.
TORRINGTON PHYSICAL THERAPY
MEDICAL HISTORY FORM

Name: _____ Today's Date: _____
 Date of Birth: _____

CHIEF COMPLAINT

Why are you seeing the PT today? _____

Current problem is a result of: Car Accident Work Accident Other (Explain) _____

Have you ever been treated for this condition before? Yes No
 By Whom? _____ When? _____

Please list any other serious illnesses _____ Age of onset _____

Please list any serious injuries _____

Please list any significant surgeries or hospitalizations and why? _____

Are you allergic to any foods or medications? Yes No If yes, please list _____

Are you allergic to latex? Yes No Have you ever had hay fever or asthma Yes No

Do you smoke? _____ Pk/day _____ Do you use drugs or alcohol? _____ Drinks/wk _____

Do you wear glasses? _____ Do you use a hearing aid? _____

At the present time, would you say that your health is excellent, very good, fair or poor? _____

REVIEW OF SYMPTOMS

Are you currently having or have you had any problems with:

	Circle One	Describe all <u>YES</u> responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Pacemaker	No Yes	_____
Bowel Movement	No Yes	_____
Bladder Problem	No Yes	_____
Diabetes	No Yes	_____
High Blood Pressure	No Yes	_____
Bleeding Problems	No Yes	_____
Balance Problems	No Yes	_____
Numbness/Tingling	No Yes	_____
Blackouts/Fainting	No Yes	_____
Psychological Problems	No Yes	_____
AIDS/HIV	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Epilepsy/Seizures	No Yes	_____
Heart Disease	No Yes	_____
Kidney Disease	No Yes	_____
Pregnancy	No Yes	_____
Osteoporosis/Osteopenia	No Yes	_____
Stroke	No Yes	_____

Would you like to learn more about natural nutritional supplements? No Yes

Would you like one of our therapists to talk to you about our weight management program? No Yes

Patient Signature: _____

Date: _____

Reviewed By: _____

Date: _____