Suburban Physical Therapy
Accessibility. Experience. Results.

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FREE SCREENING MEDICAL HISTORY

Name _____ Age_____ Date _____

Reason for Today's Visit:_____

_____

List any allergies you have to drugs, food or other items:

_____

_____

List recent major operations: Year

_____ _____

_____ _____

_____ _____

(Female Patients): Are you currently pregnant: (Please Check) ☐ Yes ☐ No

Have you had any of the following illnesses: (Please Check)

☐ Diabetes	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ High Blood Pressure	☐ Heart Attack	☐ Osteoporosis/Osteopenia
☐ Low Blood Pressure	☐ Chest Pain/Angina	☐ Asthma
☐ Congestive Heart Failure	☐ Cancer	☐ Seizures
☐ COPD/ Lung Disease	☐ Stroke	☐ Hepatitis

Other illnesses: (Please Explain): _____

_____

I authorize the above provider to perform a screening of my current injury or complaint. I understand that the Therapist will perform a series of evaluative tests which may involve range of motion and strength testing of specific body parts and joints. The Therapist may also perform certain manual therapy procedures or movements to evaluate your response and to determine your best course of treatment.	
Date	Signature of Patient