

PHOENIX PHYSICAL THERAPY AND SPORTS PERFORMANCE

PLEASE PROVIDE US WITH THE FOLLOWING IMPORTANT BACKGROUND INFORMATION. PLEASE CIRCLE YOUR ANSWER. IF YOU DO NOT UNDERSTAND A QUESTION PLEASE ASK YOUR THERAPIST AND THEY WILL ASSIST YOU. THANK YOU.

Name: \_\_\_\_\_

Please list any known allergies \_\_\_\_\_

|  |     |    |     |    |
|--|-----|----|-----|----|
| Are you latex sensitive?                         | Yes | No |     |    |
| Are you allergic to heat or cold on your skin?   |     |    | Yes | No |
| Are you pregnant or think you might be pregnant? |     |    | Yes | No |
| Do you wear a pacemaker?                         | Yes | No |     |    |

Please indicate whether you are under the care of any of the following health care providers:

|                |                           |                               |
|----------------|---------------------------|-------------------------------|
| Medical Doctor | Psychiatrist/Psychologist | Other (please specify): _____ |
| Osteopath      | Physical therapist        | _____                         |
| Dentist        | Chiropractor              | _____                         |

If you have seen any of the above within the last three months, please describe for what reasons (illness, medical condition, physical, etc) \_\_\_\_\_

MEDICAL/SURGICAL HISTORY

Please indicate if you have ever been diagnosed with any of the following conditions:

|                                    |                                  |
|------------------------------------|----------------------------------|
| Arthritis                          | Muscular dystrophy               |
| Broken bones/fracture              | Parkinson's disease              |
| Osteoporosis                       | Seizures/epilepsy                |
| Blood disorders                    | Developmental or growth problems |
| Circulation/vascular problems      | Thyroid problems                 |
| Heart problems                     | Kidney problems                  |
| Hypertension (high blood pressure) | Skin disease                     |
| Lung problems                      | Cancer                           |
| Stroke                             | Repeated infections              |
| Diabetes                           | Depression                       |
| Hypoglycemia                       | Infectious disease               |
| Head Injury                        | Ulcers/stomach problems          |
| Multiple sclerosis                 | Alcohol abuse                    |
| Chemical dependency                | Other: _____                     |

Within the past year, have you had any of the following symptoms?

|                        |                        |                     |
|------------------------|------------------------|---------------------|
| Chest pain             | Loss of balance        | Weight loss/gain    |
| Heart palpitations     | Difficulty walking     | Urinary problems    |
| Cough                  | Joint pain or swelling | Fever/chills/sweats |
| Hoarseness             | Difficulty sleeping    | Headaches           |
| Shortness of breathe   | Loss of appetite       | Hearing problems    |
| Dizziness or blackouts | Nausea/vomiting        | Vision problems     |
| Coordination problems  | Difficulty swallowing  | Fatigue             |
| Weakness in arms/legs  | Bowel problems         | Numbness/tingling   |
| Other _____            |                        |                     |

Please list any surgeries or hospitalizations, including the approximate date and reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any significant injuries for which you have been treated and the approximate date of injury:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been involved in a motor vehicle accident?                      Yes                      No  
If yes, please list the approximate date(s):\_\_\_\_\_

**FAMILY HISTORY**

Please indicate whether anyone in your immediate family (parents, siblings, grandparents) has been diagnosed with the following and list the age of onset if known:

Heart Disease\_\_\_\_\_ Psychological\_\_\_\_\_  
Hypertension\_\_\_\_\_ Arthritis\_\_\_\_\_  
Stroke\_\_\_\_\_ Osteoporosis\_\_\_\_\_  
Diabetes\_\_\_\_\_ Other:\_\_\_\_\_  
Cancer\_\_\_\_\_

**MEDICATIONS:**

Please list any prescription medications you are currently taking:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you taking any of the following nonprescription medications?

Aspirin                      Decongestants  
Advil/Aleve/Motrin/Ibuprofen                      Laxatives  
Tylenol                      Antacid  
Antihistamines                      Vitamins  
Herbal supplements                      Other:\_\_\_\_\_

**SOCIAL/HEALTH HABITS**

Do you currently use tobacco products?                      Yes                      No

If yes, how many packs per day do you smoke?\_\_\_\_\_

Have you used tobacco products in the past?                      Yes                      No

If yes, in what year did you quit?\_\_\_\_\_

How many caffeinated beverages do you drink per day?\_\_\_\_\_

Do you exercise beyond normal daily activities and chores?                      Yes                      No

If yes, please describe the type of exercise, how many times per week, and for how long each day.\_\_\_\_\_

Patient Signature:\_\_\_\_\_ Date:\_\_\_\_\_

Therapist Signature:\_\_\_\_\_ Date:\_\_\_\_\_