



Sheri Baldwin, MS, PT, ATC
 Pelvic Rehab & Physical Therapy
 Going Beyond Medication...

Medical History

Have you had previous treatment for the diagnosis we are treating you for? Yes No

If yes, where? _____

Have you had any physical therapy this year? Yes No

If yes, when? _____

Are you currently receiving home health services? Yes No

If yes, discharge date: _____ Name of home health agency: _____

Please indicate if you have or ever had any of the following:

- | | | | | | |
|----------------------|--|-------------------------|--|----------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | MRSA | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema/Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscular Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gallbladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autoimmune Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Impairment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Speech Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High/Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Strokes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulation Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently Pregnant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metal Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If other, please explain: _____

Previous surgeries (please list type and date): _____

Please list current medications with dosages: _____

I agree that the above information is found to be true and correct.

Patient/Guardian Signature _____

Date _____