Cambria Physical Therapy
The advanced care you need. The personal touch you deserve.

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