La Jolla Shores Physical Therapy

Patient Medical History

Name: _____ **Phone:** _____

Email: _____ **Age:**_____ **Date of Birth:**_____

The following information will assist your clinician in providing a safe and effective treatment plan.

Referring Physician or Other Referral: _____

Problem areas to be treated: _____

Have you been treated for this problem before: Yes: _____ No: _____

If yes, where and when? _____

What type of treatment was administered? _____

What is you medical diagnosis for this problem? _____

Any previous surgeries related to this problem? Yes: _____ Date: _____ No: _____

Are you currently taking any medication related to this problem: Yes: _____ No: _____

Please list medications: _____

Do you now have / or have had any of the following: Please circle

High Blood Pressure	Yes No	Sensitive to Heat/Ice	Yes No
Heart Disease	Yes No	Allergies	Yes No
Heart Attack	Yes No	Seizures	Yes No
Pacemaker	Yes No	Metal Implants	Yes No
Diabetes	Yes No	Dizzy Spells	Yes No
Headaches	Yes No	Balance Problems	Yes No
Kidney Problems	Yes No	Vision Problems	Yes No
Hearing Problems	Yes No	Are you pregnant	Yes No
Cancer	Yes No		

Please list any other pertinent information related to your medical history: _____

_____

_____

_____

The above information is correct to the best of my knowledge.

Patient Signature _____ **Date** _____

(Parent/Guardian to sign if patient is under 18 years of age)