MEDICAL HISTORY

RAISE THE BAR THERAPY SERVICES

Patient Name: _____ **DOB:** _____
Address: _____
Primary Ins Name: _____ **Secondary Ins Name:** _____
Phone: _____ **Email address:** _____
Preferred method of contact for upcoming appointments: ☐ text ☐ email

Have you ever, or are you presently bring treated for any of the following problems?

Heart Trouble		Yes		No	Asthma		Yes		No	Do you or have you had any of the following symptoms:					
High Blood Pressure					Emphysema										
Diabetes					Back Injury										
Headaches					Arthritis										
Dizzy Spells					Bleeding Disorder										
Fainting					Fracture					Productive Couth		Yes		No	
Epilepsy					Cancer					Coughing Blood					
Stroke					Pacemaker					Weight Loss					
Pregnancy					Implants/Metal					Appetite Loss					
Seizures					Respiratory Problems					Lethargy					
Allergies					Tuberculosis					Night Sweats					
*Specify _____					Hepatitis A/B/C					Fever					

Date of injury: _____ **How did the injury occur?** _____

Have you been hospitalized for the present problem? ☐ yes ☐ no **If yes, dates:** _____
Have you undergone surgery for the problem? ☐ yes ☐ no **If yes, dates:** _____
Have you had previous treatments for the problem? ☐ yes ☐ no **If yes, specify Types/Results of treatment:**
_____

Are you currently receiving any other health, medical, or chiropractic services or by any other organization or individual at this time? _____
_____

Last Date seen by Physician: _____ **Next appointment with Physician:** _____

Are you on any medications: ☐ yes ☐ no _____

Have you ever had any of the following for the present condition for which you are going to be treated?
EMG ☐ yes ☐ no **CAT Scan** ☐ yes ☐ no **Myelogram** ☐ yes ☐ no
X-Ray ☐ yes ☐ no **MRI** ☐ yes ☐ no

Have you every received PT/OT/Speech Services for you present condition? ☐ yes ☐ no
If YES, where and when? _____

****Medical Disclaimer and Liability:**
During your treatment at RTBTS, you will be educated about certain medical conditions and provided with specialized treatment, including modalities. Information received should no be relied upon as an alternative to the advice of your physician. If you have specific questions/concerns, contact your physician.
By signing this form, you agree to never disregard medical advice, delay physician treatment, or discontinue medical regimes given the information provided @ RTBTS.
By signing this form, you agree that the Therapists and Assistants at TRBTS are not liable for any dangers/damages arising from or related to your treatment.

I believe the above to be true and correct to the best of my knowledge:

Patient (representative) Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____