GRAPEVINE PHYSICAL THERAPY
AND SPORTS MEDICINE
PATIENT HISTORY

Name _____ Height _____ Weight _____

Family/Primary Physician _____ Referring Physician _____

Have you ever had, or do you have, any of the following?	Yes	No	Comments
Asthma, Bronchitis or Emphysema			
Shortness of Breath or Chest Pains			
Do you Smoke?			
High Blood Pressure			
Coronary Heart Disease or Angina			
Heart attack/Surgery			
Do you have a pacemaker?			
Vision or Hearing Difficulties			
Severe or Frequent Headaches			
Numbness, Weakness, Dizziness or Fainting			
Weight loss/Energy loss			
Nausea/Vomiting			
Epilepsy			
Osteoporosis			
Hernia			
Bowel or Bladder Problems/Troubles			
Thyroid Trouble/Goiter			
Diabetes			
Anemia			
Cancer or Chemotherapy/Radiation			
Infectious Diseases			
Recent Surgeries			
Swollen Joints/Arthritis			
Joint Replacement			
Any pins in joints or metal implants?			
Are you pregnant?			
Are you taking any medications?			
Reactions to medicines			
Have you ever had Physical Therapy before?			

Patient Signature _____ Date _____