

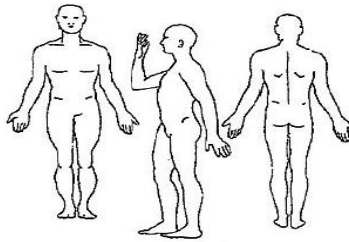
PATIENT MEDICAL HISTORY

HAVE YOU EVEN BEEN DIAGNOSED AS HAVING AND OF THE FOLLOWING CONDITIONS?								
	YES	NO		YES	NO		YES	NO
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
CHF	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>			

Are you currently pregnant? Yes No List Allergies: _____
 Do you have a pacemaker? Yes No _____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED, INCLUDING THE APPROXIMATE DATE AND REASON FOR THE SURGERY OR HOSPITALIZATION:		
Date	Surgery/Hospitalization	Reason

Please list the medication(s) you are currently taking, including pills, injections, and/or skin patches:



Please indicate areas of pain and discomfort (on the figures above) using the following symbols:
 /// = Pain *** = Numbness, no feeling at all +++ = Tingling, asleep, abnormal feeling

Please rate your pain on a scale of 0 to 10: _____ / 10 At Highest _____ / 10 At Lowest



I authorize my insurance benefits be paid directly to Central Missouri Physical Therapy dba Sport and Spine Rehab and I understand that I am financially responsible for any balance. I also authorize Central Missouri Physical Therapy dba Sport and Spine Rehab, to release any information to process my claims.

 PATIENT/GUARDIAN SIGNATURE

_____/_____/20
 DATE