Patient Name:

Today's Date:
Case:

History and Medication Intake Form

1. What is your reason for coming to therapy today?

2. When did your problem begin?

3. How did your problem start?

4. **Current Status**: Please circle the most appropriate answer and provide further comment on any "yes" responses:

A. Have you had any of the following special tests?		Notes
X-RAY	Yes No	
MRI	Yes No	
CT Scan	Yes No	
Other (please list)		
B. Have you received therapy for this problem previously?	Yes No	
C. Are you receiving other treatments for this same problem at the same time?	Yes No	
D. Have you been hospitalized in the past year **for this condition**?	Yes No	
F. Are you allergic to adhesives/tape or latex	Yes No	
G. Do you have any metal implants	Yes No	

5. Medical History (please circle the most appropriate answer and provide further comment on any "yes" responses

Do you have high blood pressure	Yes No	
Do you have diabetes	Yes No	
Do you have a current or prior history of cancer	Yes No	
Do you have a current of prior history of heart disease	Yes No	
Do you have osteoporosis	Yes No	
Do you have a pacemaker	Yes No	
Do you have a current of prior history of kidney problems	Yes No	
Females Only: Are your pregnant or feel there is a chance you may be pregnant	Yes No	

6. Medications

A. Are you allergic to any medications? **Yes** **No** **Please List**:____

Please list or provide us with a list of all medications, including all prescriptions and over the counter medications.

7. **What are your goals as a result of attending therapy? (please check ALL appropriate boxes)**:

- ❑ Decrease Pain
- ❑ Less Difficulty with work activities
- ❑ Improved Sleep
- ❑ Improve Movement
- ❑ Return to recreational/sporting activities
- ❑ Improve Strength
- ❑ Stand Longer
- ❑ Sit Longer
- ❑ Less Difficulty with home activities
- ❑ Other: ____________________

Patient or Guardian Signature	Date