



**P R E M I E R**  
**PHYSICAL THERAPY**

*Where it's all about you... all the time.*

### **Confidential Patient Health History Form**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**Please place an "X" in the space provided if you have had any of the following conditions:**

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|--|--|--|
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Pacemaker         |
| <input type="checkbox"/> Prolapsed Mitral Valve      | <input type="checkbox"/> Artificial Prosthesis | <input type="checkbox"/> Metal Implant     |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Hearing Loss          | <input type="checkbox"/> Swollen Ankles    |
| <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> Sinusitis         |
| <input type="checkbox"/> AIDS                        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Leukemia                    | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Mental/Psychiatric Disorder | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Heart Murmur      |
| <input type="checkbox"/> Thyroid Disease             | <input type="checkbox"/> Night Pain            | <input type="checkbox"/> Unexpected Weight |
| <input type="checkbox"/> Other _____                 |  | Loss/Gain                                  |

**Please list any surgeries you have had related to your current physical therapy problem:**

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**Please list any previous surgeries:**

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**Please list any medications that you take:**

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**Who is your family physician?** \_\_\_\_\_

**When was your last physical exam?** \_\_\_\_\_