P R E M I E R
PHYSICAL THERAPY
Where it's all about you… all the time.

Health History

All information you provide is personal and confidential. This information will enable us to better understand your health and fitness habits as well as inform you of any potential risks. Please consult your physician before beginning any type of exercise program.

Do you now, or have you had in the past: Yes or No. If yes, please explain.

1. History of heart problems, chest pain or stroke?

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2. Increased blood pressure?

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3. Any chronic illness or condition?

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4. Dizziness, loss of balance or loss of consciousness?

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5. Difficulty with physical exercise?

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6. Advice from physician not to exercise?

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7. Surgeries? ______________________________________

8. Pregnancy (now or within the last 3 months)?

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9. History of breathing or lung problems?

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10. Swollen, stiff, or painful joints?

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11. Foot problems?

12. Back problems?

13. Any significant vision or hearing problems?

14. Diabetes or thyroid condition?

15. Cigarette smoking habit?

16. Fibromyalgia?

17. Increased blood cholesterol?

18. History of heart problems in immediate family?

19. Asthma?

Do you have any other medical conditions or problems not previously mentioned? If yes, please explain.

Please list any medications, vitamins, supplements, etc. that you are currently taking.

Please list all known allergies.

Family History

Have any of your BLOOD relatives had:

____Heart attack under the age of 50	____Asthma
____Stroke under the age of 50	____Heart operations
____High blood pressure	____Obesity
____Elevated cholesterol	____Diabetes
____Osteoporosis	
____Leukemia or cancer under the age of 60	