WEST POINT

PHYSICAL THERAPY CENTER

PATIENT HISTORY INFORMATION

Patient Name _____
Last First Middle Initial

Age _____ Height _____ Weight _____ Occupation _____ Date Of Injury _____

Do you do heavy lifting at work? _____ Are you right or left Handed? _____

List all the current medications being taken right now? _____

_____

_____

List the Allergies that you May Have _____

_____

Please Place a **check** in the box if you have been treated for or have a history of the following:

- ☐ Heart Disease
- ☐ Mental / Emotional Problems
- ☐ Ear Problems
- ☐ Skin Problems
- ☐ Numbness/Tingling
- ☐ Lung Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Recent Fractures
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Circulatory Problems
- ☐ Eye Problems
- ☐ Cancer
- ☐ Diabetes

_____ I have not been treated for any of the above listings

Please explain all of the above checked items. _____

_____

Do you have any metal in your body? ____ Explain _____

Are you pregnant? _____

Signature

_____ _____

Signature Date