BLASER PHYSICAL THERAPY
PATIENT HEALTH HISTORY SCREENING

FULL NAME: _____ DATE: _____

Please describe your injury/symptoms which required you to come to Blaser Physical Therapy. If accident related (work/ automobile/other) please give details:

_____

_____

FUNCTIONAL LIMITATIONS DUE TO INJURY:

_____

DATE OF INJURY: _____

WERE X-RAYS TAKEN? YES____NO____ WHERE?_____

WERE MRI'S PERFORMED? YES___NO___WHERE?_____

MEDICATIONS:_____

_____

ALLERGIES:_____

PREVIOUS MEDICAL HISTORY: CHECK ALL THAT APPLY

_____ Vision Impairment	_____Pregnant (at this time)
_____ Hearing Difficulties	_____Shingles
_____Arthritis/Bone problems	_____Previous Surgeries
_____ Speech Impairment	_____Back Problems
_____ Fainting/Dizzy Spells	_____Stomach Ulcers
_____ Epilepsy/Convulsions/Seizures	_____Hernia
_____Allergies/Wheezing/Asthma	_____Bowel Problems/Difficulties
_____Shortness of breath	_____Menstruation problems
_____TB	_____Metal Implants
_____Pacemaker	_____Diabetes/Insulin Dependent
_____Chest Pain/Pressure	_____Kidney Problems
_____Heart Problems	_____Skin allergies/Disease
_____Varicose Veins	_____Alcoholism/Drug Addiction
_____Circulatory Problems	_____Mental Health Problems
_____HIV/AIDES	_____Cancer
_____Hepatitis (Type?)	_____High Blood Pressure
_____Blood Transfusions	_____Low Blood Pressure
_____MRSA	_____Thyroid

Please provide a brief description for each item checked above. Use the back of this page if needed.

_____

_____

Are you aware of any precautions for each item checked above? Yes _____ No _____
Please describe:

_____

_____

AUTHORIZATION OF TREATMENT

I hereby authorize the staff of Blaser Physical Therapy, Inc. to evaluate and perform the treatment plan, which my physician has prescribed.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Print Name of Patient/ Parent / Legal Guardian Relationship to Patient