

**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:

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FUNCTIONAL LIMITATIONS DUE TO INJURY:

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DATE OF INJURY: \_\_\_\_\_

WERE X-RAYS TAKEN? YES \_\_\_ NO \_\_\_ WHERE? \_\_\_\_\_

WERE MRI'S PERFORMED? YES \_\_\_ NO \_\_\_ WHERE? \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

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ALLERGIES: \_\_\_\_\_

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PREVIOUS MEDICAL HISTORY: CHECK ALL THAT APPLY

<input type="checkbox"/> Vision Impairment	<input type="checkbox"/> Pregnant (at this time)
<input type="checkbox"/> Hearing Difficulties	<input type="checkbox"/> Shingles
<input type="checkbox"/> Arthritis/Bone problems	<input type="checkbox"/> Previous Surgeries
<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Back Problems
<input type="checkbox"/> Fainting/Dizzy Spells	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Epilepsy/Convulsions/Seizures	<input type="checkbox"/> Hernia
<input type="checkbox"/> Allergies/Wheezing/Asthma	<input type="checkbox"/> Bowel Problems/Difficulties
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Menstruation problems
<input type="checkbox"/> TB	<input type="checkbox"/> Metal Implants
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Diabetes/Insulin Dependent
<input type="checkbox"/> Chest Pain/Pressure	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Skin allergies/Disease
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Alcoholism/Drug Addiction
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Mental Health Problems
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Cancer
<input type="checkbox"/> Hepatitis (Type?)	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> MRSA	<input type="checkbox"/> Thyroid

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

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Are you aware of any precautions for each item checked above? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe:

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**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