Medical Form

In our effort to provide *care at its best*, please complete this form.

Name:____ DOB:____________

Please check the box's of the conditions you have had or currently have

Systemic: Have you ever been diagnosed with HIV, AIDS, or Hepatitis?	
Cardiovascular: Do you have high or low blood pressure?	
Do you have a pacemaker or have you had chest pain/angina or other heart problems?	
Pulmonary: Do you have any respiratory problems (asthma, COPD, emphysema, etc)?	
Neurological: Have you had a stroke, head injury, concussion or any seizure disorder?	
Have you been diagnosed with Multiple Sclerosis, Polio, Cerebral Palsy or other condition?	
Have you experienced any loss of balance or falls?	
Musculoskeletal: Do you have any artificial joints/ prosthesis?	
Do you have osteoporosis, osteopenia or any type of arthritis?	
Have you been diagnosed with Fibromyalgia, Chronic Fatigue or similar condition?	
Psychological: Do you have depression, anxiety or any other psychological diagnosis?	
Genituoruninary: Are you or could you be pregnant?	
Do you have any loss of bladder control or function?	
Endocrine: Do you have diabetes?	
Skin: Are you allergic/sensitive to latex and/or tape?	
Do you or have you ever had Cancer?	
Have you had any unexplained weight loss or gain?	
Do you have night sweats, fevers or chills?	
Do you smoke cigarettes, cigars or pipes? /per day	
Have you had any other physical/speech therapy this year?	
Have you ever had homecare services?	

Please list any medications & dosages you are taking:_______________________________

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Please list any disease, condition or surgery not listed above:__________________________

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Are you concerned with any of the following health issues? ***Please Circle***

Joint Flexibility, Headaches/migraines, Circulation/Artery/Vein Health, Skin problems, Fatigue, Blood Sugar Maintenance, Muscle Pain, Digestive Health, Muscle Coordination, Diabetes, Depression, Cholesterol, Respiratory problems, Healthy Blood Pressure

Patient/Guardian Signature:______________________________Date:____________