

# BETHESDA

PHYSICAL THERAPY

## PATIENT INFORMATION FORM

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Age: \_\_\_\_\_

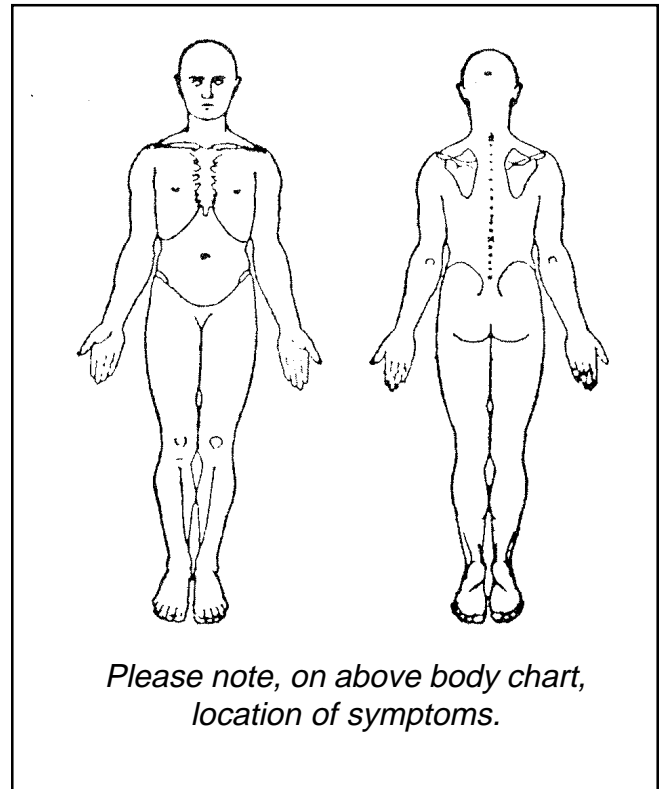
Physician: \_\_\_\_\_

Date of Onset: Injury/Program/Surgery: \_\_\_\_\_

Briefly state previous treatment, if any: \_\_\_\_\_

*Do you have now, or have you ever had, any of the following?*

- |  |     |    |
|--|-----|----|
| DIABETES   | YES | NO |
| ALLERGY TO COLD  | YES | NO |
| HIGH BLOOD PRESSURE                                      | YES | NO |
| OTHER ALLERGIES  | YES | NO |
| PACEMAKER  | YES | NO |
| PREVIOUS SURGERY   | YES | NO |
| CHRONIC HEADACHES  | YES | NO |
| SEIZURES   | YES | NO |
| KIDNEY PROBLEMS  | YES | NO |
| METAL IMPLANTS   | YES | NO |
| NERVOUS DISORDERS  | YES | NO |
| DIZZINESS  | YES | NO |
| HERNIA   | YES | NO |
| CANCER   | YES | NO |
| ALLERGY TO HEAT  | YES | NO |
| PREGNANT   | YES | NO |
| BONE DISEASE   | YES | NO |
| OSTEOPOROSIS   | YES | NO |
| FRACTURES  | YES | NO |
| BOWEL PROBLEMS   | YES | NO |
| BLADDER PROBLEMS   | YES | NO |
| RECENT WEIGHT LOSS                                       | YES | NO |
| PINS & NEEDLES   | YES | NO |
| CIRCULATORY DISEASE                                      | YES | NO |
| PROBLEMS WITH BOTH ARMS OR BOTH LEGS<br>AT THE SAME TIME | YES | NO |



If YES to any of the above, please explain and give appropriate details: (use back of sheet, if necessary):

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