SPECIALIZED ORTHOPEDIC PHYSICAL THERAPY, INC

MEDICAL HISTORY

Name: ______________________________ **Date:** ______________

Are you currently taking any medications? Please list:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Do you have any allergies? Please list:

______________________ ______________________
______________________ ______________________

Please list previous orthopedic injuries and surgeries (if applicable). **Dates?**

______________________________ ______________
______________________________ ______________
______________________________ ______________

Have you ever had physical therapy before? Injury type: **Dates?**

______________________________ ______________
______________________________ ______________
______________________________ ______________

Which of the following medical services have you had for the *current* injury?

Please check all that apply:

_____ Emergency Room Care
_____ General / Family Practitioner / Internist (circle one)
_____ Orthopedic
_____ Neurologist
_____ Rheumatologist
_____ Physiatrist
_____ Chiropractor
_____ Acupuncture / Massage Therapy
_____ X-Ray
_____ MRI
_____ CT Scan
_____ Blood-workup
_____ EMG-EEG
_____ Mylogram / Arthrogram
_____ Other: ______________________
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