Mid-Nebraska Physical Therapy & Sports Center
Patient Medical History & Physical Condition

~~ Please fill out completely ~~

Name: _____ **Referring Physician :** _____

Date of next follow-up appointment w/ Referring Physician: _____

Please describe the problem to be treated: _____

Date of Injury/ Onset of symptoms: _____

Is condition accident related? YES / NO If yes, was it: WORK / AUTO / OTHER _____

Have you been treated for this problem previously? YES / NO If yes, please state specifics:

_____

Have you had any of the following at any time? (Please circle Y or N)

High Blood Pressure	Y	N	Sensitivity to Heat or Ice	Y	N
Heart Disease	Y	N	Allergies	Y	N
Pacemaker	Y	N	Diabetes	Y	N
Seizures	Y	N	Metal Implants	Y	N
Balance Problems	Y	N	Plastic Implants	Y	N
Vision Problems	Y	N	Do You Use Tobacco?	Y	N
Cancer	Y	N	Are You Pregnant?	Y	N

If you answered yes to any, please explain and give approximate date: _____

_____

Please list any other medical conditions that would interfere with treatment: _____

_____

Have you had any major illness or surgery in the past year? _____

_____

Are you currently taking medications? YES / NO If yes, please list: _____

_____

Family Physician: _____

The above information is correct to the best of my knowledge.

_____ _____

Patient, Parent or Guardian Signature **Date**