**Existing or Relevant Previous Conditions**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Allergies | ⃝ Yes ⃝ No | Diabetes | ⃝ Yes ⃝ No | Multiple Sclerosis | ⃝ Yes ⃝ No |
| Anemia | ⃝ Yes ⃝ No | Dizzy Spells | ⃝ Yes ⃝ No | Muscular Disease | ⃝ Yes ⃝ No |
| Anxiety | ⃝ Yes ⃝ No | Emphysema/ Bronchitis | ⃝ Yes ⃝ No | Neuropathy | ⃝ Yes ⃝ No |
| Arthritis-Osteo | ⃝ Yes ⃝ No | Fibromyalgia | ⃝ Yes ⃝ No | Osteoporosis | ⃝ Yes ⃝ No |
| Arthritis-Rheumatoid | ⃝ Yes ⃝ No | Fractures | ⃝ Yes ⃝ No | Parkinson's | ⃝ Yes ⃝ No |
| Asthma | ⃝ Yes ⃝ No | Gallbladder Problems | ⃝ Yes ⃝ No | Prosthesis | ⃝ Yes ⃝ No |
| Autoimmune Disorder | ⃝ Yes ⃝ No | Headaches | ⃝ Yes ⃝ No | Seizures | ⃝ Yes ⃝ No |
| Brain Injury | ⃝ Yes ⃝ No | Hearing Impairment | ⃝ Yes ⃝ No | Smoker | ⃝ Yes ⃝ No |
| Cancer | ⃝ Yes ⃝ No | Hepatitis | ⃝ Yes ⃝ No | Speech Problems | ⃝ Yes ⃝ No |
| Cardiac Conditions | ⃝ Yes ⃝ No | High/low blood pressure | ⃝ Yes ⃝ No | Spinal DDD | ⃝ Yes ⃝ No |
| Cardiac Pacemaker | ⃝ Yes ⃝ No | High cholesterol | ⃝ Yes ⃝ No | Spinal Stenosis | ⃝ Yes ⃝ No |
| Chemical Dependency | ⃝ Yes ⃝ No | HIV/AIDS | ⃝ Yes ⃝ No | Strokes | ⃝ Yes ⃝ No |
| Circulation Problems | ⃝ Yes ⃝ No | Incontinence | ⃝ Yes ⃝ No | Thyroid Disease | ⃝ Yes ⃝ No |
| COPD | ⃝ Yes ⃝ No | Kidney Problems | ⃝ Yes ⃝ No | Tuberculosis | ⃝ Yes ⃝ No |
| Currently Pregnant | ⃝ Yes ⃝ No | Metal Implants | ⃝ Yes ⃝ No | Vertigo | ⃝ Yes ⃝ No |
| Depression | ⃝ Yes ⃝ No | MRSA | ⃝ Yes ⃝ No | Vision Impairment | ⃝ Yes ⃝ No |

**Height:** \_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_\_\_\_

**Fall History**

* Injury as a result of a fall in the past year? Date of injury or onset:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Two or more falls in the last year?

**Surgical History**

Body Region:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Body Region:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Body Region:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Body Region:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**Current Medications**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MEDICATION** | **DOSE** | **FREQUENCY** | **REASON FOR USE** | **HOW IS IT ADMINISTERED** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

* **Currently not taking any medications**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**