NEW ROCHELLE PHYSICAL THERAPY

MEDICAL INFORMATION

Name: ______________________ **Date:** __________
Family Physician: ______________________ **Phone:** __________
Address: ______________________ **City/State/Zip:** __________

PLEASE ANSWER THE FOLLOWING:

Do you presently have, or, have you ever had:

Diabetes? ......Type I ___ Type II ___......................................Yes ___ No ___
Hepatitis? ....Yes ___ No ___
High Blood Pressure? ....Yes ___ No ___
If yes, is it controlled?..Yes ___ No ___
Difficulty Breathing or Lung problems? ....Yes ___ No ___
Cancer? ....Yes ___ No ___
Abdominal pain (prolonged)? ....Yes ___ No ___
Allergies to Medication? ....Yes ___ No ___
Abnormal heart Condition? ....Yes ___ No ___
If yes, Do you have a Pacemaker? ....Yes ___ No___
Infectious disease? ....Yes ___ No ___
Sensitivity to heat or cold? ....Yes ___ No ___
Headaches (persistent)? ....Yes ___ No ___
Lasting or prolonged pain? ....Yes ___ No ___
If yes, what area of the body? ______________________
Presently Pregnant? ....Yes ___ No ___
IF YOU ANSWERED YES TO ANY OF THE ABOVE , EXPLAIN HERE ______

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Are you taking medication now? ....Yes ___ No ___
If yes, for what reason? ______________________
List medications presently taking: ______________________

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Has a physician ever prescribed steroids for you? (prednisone) ......Yes ___ No ___
Has physician ever instructed you to limit your activity?
If yes, how? ______________________

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Do you have limitations to exercise?
If yes, explain: ______________________

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Do you have a DO NOT RESUSITATE (DNR) order in effect?.....Yes __ No __

Signature: ______________________ **Date:** __________