ALTITUDE PHYSICAL THERAPY

Patient Health Information

NAME: _____ DATE OF BIRTH: _____

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? Yes No

List any other allergies we should know about: _____

How would you rate your overall health: Excellent Good Fair Poor

Medical History:						In the past 3 months:		
Depression	Yes	No	High Blood Pressure	Yes	No	Panic Attacks/ Anxiety	Yes	No
Diabetes	Yes	No	Multiple Sclerosis	Yes	No	Parkinson's Disease	Yes	No
Fibromyalgia	Yes	No	Osteoporosis	Yes	No	Rheumatoid Arthritis	Yes	No
Heart Disease	Yes	No	Pacemaker	Yes	No			

Are there any other medical conditions (not listed below)?: _____

Surgeries (Date and Reason): _____

_____

Do you or have you ever smoked tobacco? If yes, _____ packs/ day x _____ years Last tobacco use: _____

Prescribed Medications:_____

Are you taking any light sensitive medications?: Yes No

Are you taking any blood thinners?: Yes No

Over the counter medications:

____ Aspirin ____ Tylenol ____ Advil/ Aleve/ Ibuprofen ____ Antacid

____ Laxatives ____ Decongestants ____ Vitamins/ Minerals ____ Other: _____

Patient's Signature: _____ Date: _____

Please Print Name: _____