

REMOBILITY PHYSICAL THERAPY
3901 Roswell Rd Ste 100A, Marietta GA 30062-8811
Tel: 770-578-4343, Fax: 770-578-4342
www.remobility.com

PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

Date of Birth: _____ Weight: _____ Height: _____ Occupation: _____

Drug/Supplement Allergies: _____

Environmental/Food Allergies: _____

Special Diet _____

State of health: ___Excellent ___Good ___Fair ___Poor Are you currently on disability? ___

Medications/Supplements you are currently taking: (Please give copy of list to therapist, if you have one)



All doctors you are currently seeing:

Specialty:

_____	_____
_____	_____
_____	_____
_____	_____

Conditions you have experienced (**please check twice if this has occurred within the last 6 months**):

<input type="checkbox"/> Anemia	<input type="checkbox"/> Parkinson's Syndrome
<input type="checkbox"/> Arthritis ___ Degenerative ___ Rheumatoid	<input type="checkbox"/> Repeated Infections _____
<input type="checkbox"/> Asthma ___ Triggered by Exercise	<input type="checkbox"/> Smoke cigarettes/cigars _____ per day
<input type="checkbox"/> Bleed Easily	<input type="checkbox"/> Vascular Problems
<input type="checkbox"/> Bone Fractures _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Brain Injury/Stroke	<input type="checkbox"/> Treated by Chiropractor
<input type="checkbox"/> Cancer of _____	Who? _____
<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> Past Physical Therapy
<input type="checkbox"/> Chronic Depression	Where? _____
<input type="checkbox"/> Chronic Diarrhea	
<input type="checkbox"/> Chronic Leg cramps	
<input type="checkbox"/> Chronic Urine Leakage	
<input type="checkbox"/> Diabetes Type ___I ___II	
<input type="checkbox"/> Drug/Alcohol Addiction	
<input type="checkbox"/> Epilepsy/Seizures	
<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Heart Pacemaker	
<input type="checkbox"/> Heart Problems _____	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> HIV/Aids	
<input type="checkbox"/> Low Blood Pressure	
<input type="checkbox"/> Osteoporosis	

Please list any previous surgical procedures and give the approximate dates.

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____