Elder Athlete Physical Therapy

Medical History

Name: **Date of Birth:** **Date:_____**

Existing or Relevant Previous Conditions Circle Yes or No

Allergies	Yes / No	Emphysema/Bronchitis	Yes / No	Multiple Sclerosis	Yes / No
Anemia	Yes / No	Fibromyalgia	Yes / No	Muscular Disease	Yes / No
Anxiety	Yes / No	Fractures	Yes / No	Osteoarthritis	Yes / No
Asthma	Yes / No	Gallbladder Problems	Yes / No	Osteoporosis	Yes / No
Autoimmune Disorder	Yes / No	Headaches	Yes /No	Parkinsons	Yes / No
Cancer	Yes / No	Hearing Impairment	Yes / No	Rheumatoid Arthritis	Yes / No
Cardiac Conditions	Yes / No	Hepatitis	Yes / No	Seizures	Yes / No
Cardiac Pacemaker	Yes / No	High/Low Blood Pressure	Yes / No	Smoking	Yes / No
Chemical Dependency	Yes / No	High Cholesterol	Yes / No	Speech Problems	Yes / No
Circulation Problems	Yes / No	HIV/AIDS	Yes / No	Strokes	Yes / No
Currently Pregnant	Yes / No	Incontinence	Yes / No	Thyroid Disease	Yes / No
Depression	Yes / No	Kidney Problems	Yes / No	Tuberculosis	Yes / No
Diabetes	Yes / No	Metal Implants	Yes / No	Vision Problems	Yes / No
Dizzy Spells	Yes / No	MRSA	Yes / No		

What other condition or symptom do you want to bring to our attention?:

Fall History

Are you afraid of falling? _____

Have you fallen in the last year? _____

If yes, how many times and please describe most recent fall(s):

_____

_____

_____

What are your goals for physical therapy?

_____

_____

_____

_____

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Current Medications

Drug: _____ Reason Taking: _____

Drug: _____ Reason Taking: _____

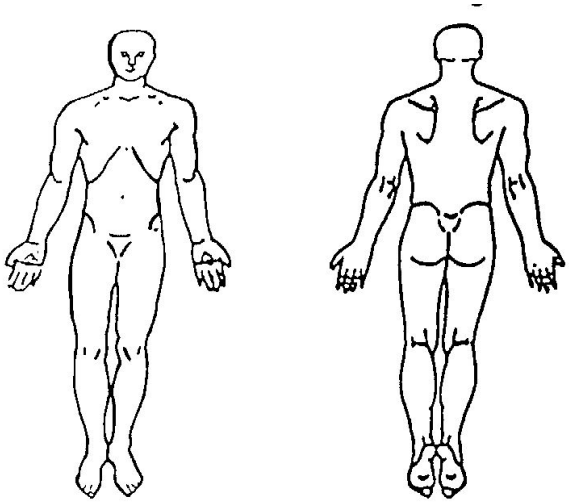
Drug: _____ Reason Taking: _____

If you prefer, just attach a list.

Primary Care Physician _____ Phone number: _____

Referring Physician _____ Phone number: _____

Please shade in areas of concern on the diagrams below:



_____Date_____

Patient Signature