DIRECT ACCESS THERAPY INC.

Patient Medical History

Name _____

Family Physician _____ Referring Physician _____

Is an attorney involved in this case? YES / NO

Have you had any surgery for this injury? YES / NO Type of Surgery _____

List any prescription or non-prescription medication that you are currently taking.

_____

_____

Describe any medical services that you have received for this injury.

_____

_____

Do you now have or have you ever had any of the following?

	YES	NO	COMMENTS
Allergies	___	___	_____
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
Pacemaker	___	___	_____
Dizziness / Balance Disorders	___	___	_____
Diabetes	___	___	_____
Stroke / CVA	___	___	_____
Hepatitis	___	___	_____
Tuberculosis	___	___	_____
Cancer	___	___	_____
Severe or frequent headaches	___	___	_____
Unexplained weight loss	___	___	_____
Bowel and bladder problems	___	___	_____
Arthritis	___	___	_____
Osteoporosis	___	___	_____
Rheumatoid Arthritis	___	___	_____
Depression / Psychological issues	___	___	_____
Hernia	___	___	_____
Weakness	___	___	_____
Any pins or metal implants	___	___	_____
Any injury / surgery to the			
-Head	___	___	_____
-Neck	___	___	_____
-Shoulder	___	___	_____
-Elbow / hand / fingers	___	___	_____
-Lower back / pelvis	___	___	_____
-Hip / Knee / Ankle / Foot	___	___	_____
Tobacco use	___	___	_____
Are you pregnant	___	___	_____

What are your rehabilitation goals ? _____

Patient / Guardian Signature _____ Date _____/_____/_____