Freedom Physical Therapy & Fitness
5310 Acton Highway, Suite 106
Granbury, TX 76049
Phone 817-326-1375 Fax 817-326-2068

MEDICAL HISTORY FORM

Patient Name:____ **Date**:_____________________________________

Referring Physician:_____________________________________**Family Physician**:_______________________________

Do you have any of the following conditions (circle those that apply): Diabetes type 1 Diabetes type 2

High Blood Pressure Cardiovascular Disease Pulmonary Disease History of Cancer

Do you have other medical history we should know about?:
____

Have you had a surgery/surgeries in the past year? YES NO

If yes, please explain:____

What is your goal in therapy? ____

When did your current symptoms begin?____

What caused your current symptoms to begin?____

Please list your current medications:

Name of Medication	Dosage	Purpose	When Taken

Please rate your pain on a 0 to 10 scale, with 0 = no pain, and 10 = emergency room pain:

Current pain on scale from 0 to 10: 0 – 1 – 2- 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Worst pain on scale from 0 to 10: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Least pain on scale from 0 to 10: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

I certify that this information is complete and correct: ____
(Patient Signature)