Colette A Sippel Physical Therapy,LLC

Patient Medical History Profile

Name:________________________________________ Date of Birth:_________________________________

Referring Doctor:____________________________________________________________________________

List your chief complaint and health problem that you would like to address________________________

____________________________________________________________________________________________

Have you had any diagnostics for this condition? please Circle) X-Ray MRI CT

Have you been treated for this condition in the last 3 months (please Circle) YES or NO

What type of Treatment have you had? ________________________________________________________

Have you had any surgeries in the last 3 years____________________________________________________

Have you had any fractures or sprains in the last 3 years (please circle) Yes No

If yes, please list location of Fracture or sprain__________________________________________________

Medications: (please Circle and list all medications you are currently taking) Aspirin Ibuprofen

Coumadin, Prednisone______________________________________________________________

Allergies: medications, food, etc.______________________________________________________

Exercise when Injury free:____________________________________________________________

Have you been diagnosed with any condition we should be aware of? Asthma, Heart Disease, High Blood Pressure, Diabetes_________________________________________________

For Women Only: Are you or could you be Pregnant? (please Circle) YES or NO

Name_____________________________________________Date_____________________________