**ALDERWOOD PHYSICAL THERAPY & REHAB SERVICES**
***MEDICAL HISTORY***

**Name: _____ Date: _____**

**Reason for visit: _____**

**How did this injury/condition occur? (Please note if motor vehicle accident or work injury):**

**_____**

**_____**

**When did this injury/condition occur? _____**

**What makes it worse?: _____**

**_____**

**What makes it better?: _____**

**_____**

**Have you had prior physical therapy for this injury/condition? _____**

**Have you had any imaging for this body part/condition (MRI, X-Ray, CT, U/S)? □ Yes □ No**

**Type of imaging: _____ Date: _____**

**Physician: _____ Location: _____**

**Have you had any operations specific to this body part/condition? □ Yes □ No**

**Type of operation: _____ Date: _____**

**Physician: _____ Location: _____**

**Current Medications: _____**

**Allergies: _____**

**Other Medical Conditions (circle):**

| | | |
|---|---|---|
| **Infections** | **Breathing** | **Heart** |
| **Drug Use** | **Psychiatric** | **Diabetes** |
| **Kidney** | **Gastrointestinal** | **Cancer** |
| **Blood/Veins** | **Chronic Fatigue** | **Lymphedema** |

**Other: _____**