# Livermore Physical Therapy
# Pertinent Medical History

Name: ______________________ Age: ________ Date: ______________

Referring Dr. :______________________ Date of Injury: ______________

What is your main complaint or problem? ______________________

Date of onset: ______________ How did it occur? ______________________

Date of surgery: ______________ Type: ______________________

**Do you have, or have you had any of the following? (Please check all that apply)**

High Blood Pressure _______
Diabetes _______
Heart Attack _______
Heart Disease _______
Pacemaker _______
Headaches _______
Kidney Problems _______
Nervous Disorder _______
Seizures _______
Allergies to Heat _______
Allergies to Ice _______
Hernia _______
Metal Implants _______
Cancer _______

Are you currently taking any medication? ________
If yes, please list them: ______________________
______________________
______________________

Other Allergies (Please List) _______
______________________
______________________

Previous Surgeries (Please List) _______
______________________
______________________

**If female, are you pregnant or trying to become pregnant? YES NO**
**Do you have another appointment with your doctor? YES NO When? ______________**

**The above information is correct to the best of my knowledge. I understand by my signature below, I am fully consenting to treatment by Livermore Physical Therapy.**

______________________ ______________________
**Patient/Guardian Signature** **Date**