FREEDOM PHYSICAL THERAPY
5310 Acton Highway, Suite 106
Granbury, TX 76049
(817)326-1375

MEDICAL HISTORY FORM

Patient name: _____ Date: _____

Referring physician: _____ Family Physician: _____

Do you have any of the following conditions? (circle all 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?

_____

PLEASE LIST YOUR CURRENT HEIGHT _____, and WEIGHT _____.

Have you had surgery 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 0-10 scale, with 0 = no pain, and 10 = emergency room pain

Current pain **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

Worst pain **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

Least pain **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

I certify that this information is complete and correct: _____

(Patient Signature)