

Pacific Water Therapy Medical History Form

Patient Name: _____

Age: _____

Reason for therapy: _____

Current medications: _____

Allergies: _____

Do you have any previous history of: (please circle yes or no and explain, providing approximate dates)

Yes No – Heart Condition/Heart Attack _____

Yes No – Stroke _____

Yes No – Diabetes _____

Yes No – Asthma _____

Yes No – High Blood Pressure _____

Yes No – Cancer _____

Yes No – Anemia _____

Yes No – Seizures/Epilepsy _____

Yes No – Severe/Chronic Headaches _____

Yes No – Arthritis _____

Yes No – Pacemaker _____

Yes No – Osteoporosis _____

Yes No – Kidney Disease _____

Yes No – Hepatitis/Jaundice _____

Yes No – Loss of Hearing _____

Yes No – Circulatory Problems _____

Yes No – Recent Weight Loss/Gain _____

Yes No – Dizziness/Loss of balance _____

Yes No – Incontinence _____

Yes No – Is there any chance you may be pregnant at this time? If Yes, Due Date: _____

Yes No – Other _____

During the past 5 years have you: (please circle yes or no and explain)

Yes No - Been admitted to hospital or had surgery?

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Yes No - Had any previous orthopedic problems or injuries?

Yes No - Received any physical therapy treatments? For what condition(s)? _____

Regarding the condition that brings you here today: (please circle yes or no and explain)

Yes No - Are you currently receiving treatments from another medical provider? (ie. Home health, chiropractic, etc.)

Yes No - Have you had any special medical tests or studies? (ie. X-Ray, MRI, etc.)

Patient signature and date

Therapist signature and date