Adirondack Physical Therapy and Sports Rehabilitation, P.C.

PERSONAL HEALTH HISTORY

Please check any of the following that apply to you (Past or Present):

____Cancer
____Diabetes
____Allergies
____Anemia
____Hearing Loss
____Visual Problems
____Kidney Disease
____Heart Attack
____Pacemaker
____Heart Disease/Condition
____Bowel/Bladder Incontinence

____Respiratory Disease
(e.g.: Asthma, Emphysema)
____High Blood Pressure
____Low Blood Pressure
____Seizures
____Stroke
____Arthritis
____Osteoporosis
____Pregnancy (Past or Present)
____HIV
____Hepatitis

Please check any of the following symptoms you experience:

____Joint Pain ____Numbness ____Paralysis ____Pins & Needles ____Swelling

Surgeries: ____

____

Diagnostic Tests (Please list dates and results):____

____

Additional Information:____

____

INFORMED CONSENT

I hereby desire to engage in, voluntarily or under the orders of a physician, evaluation and treatment at Adirondack Physical Therapy and Sports Rehabilitation, PC.

______________________________ ______________________________

Signature of Patient Date

______________________________ ______________________________

Guardian Signature (if under 18 y/o) Date