Allied Health Solutions, LLC

# MEDICAL HISTORY FORM

NAME _____ DATE _____

Are you presently working? ☐ Y ☐ N

Date of injury / onset _____

Have you experienced these symptoms before? ☐ Y ☐ N

Have you had a related surgery? ☐ Y ☐ N

If Yes, please give date _____

If female, are you pregnant? ☐ Y ☐ N

Do you have or have you had any of the following:

| | | | |
|---|---|---|---|
| Diabetes | ☐ Y ☐ N | Metal Implants/Pacemaker | ☐ Y ☐ N |
| Chest Pain/Angina | ☐ Y ☐ N | Fractures | ☐ Y ☐ N |
| Osteoarthritis | ☐ Y ☐ N | Dizziness/Fainting | ☐ Y ☐ N |
| High Blood Pressure | ☐ Y ☐ N | Cancer | ☐ Y ☐ N |
| Heart Disease | ☐ Y ☐ N | Stroke | ☐ Y ☐ N |
| Seizures | ☐ Y ☐ N | Asthma/Breathing Difficulty | ☐ Y ☐ N |

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

Do you have any allergies? ☐ Y ☐ N

If yes, please list _____

Are you presently taking any medication? ☐ Y ☐ N

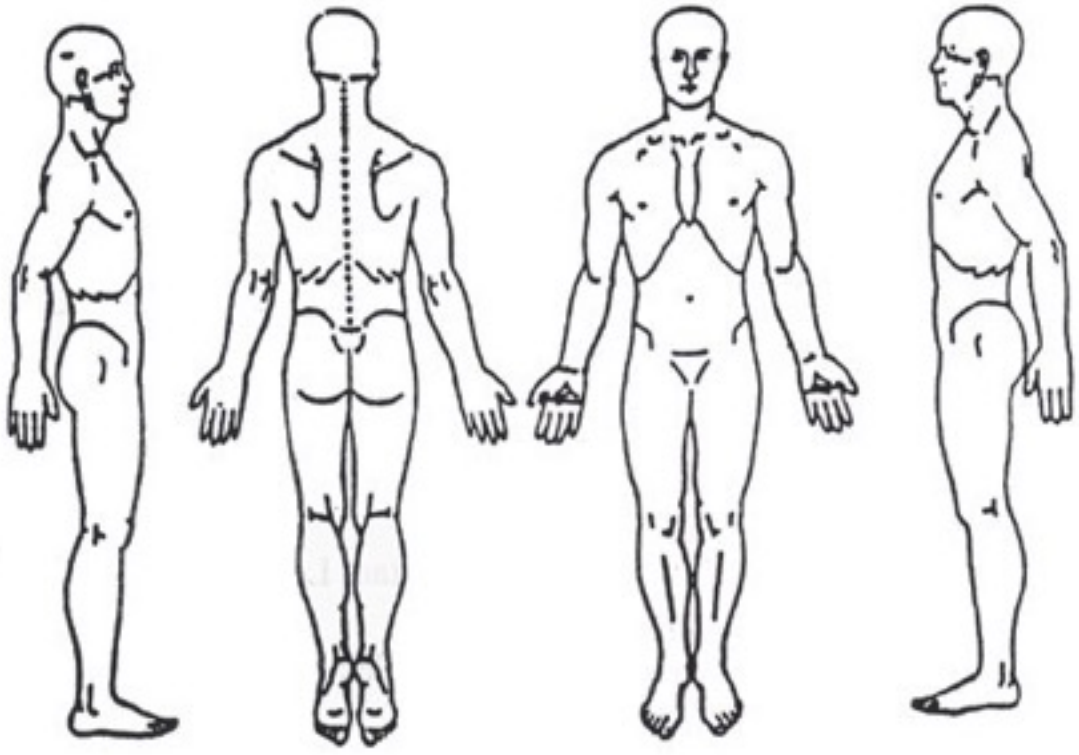
If yes, please list what medication and for what condition

_____

_____

Do you participate in any sports, exercise program or activities on a regular basis? ☐ Y ☐ N

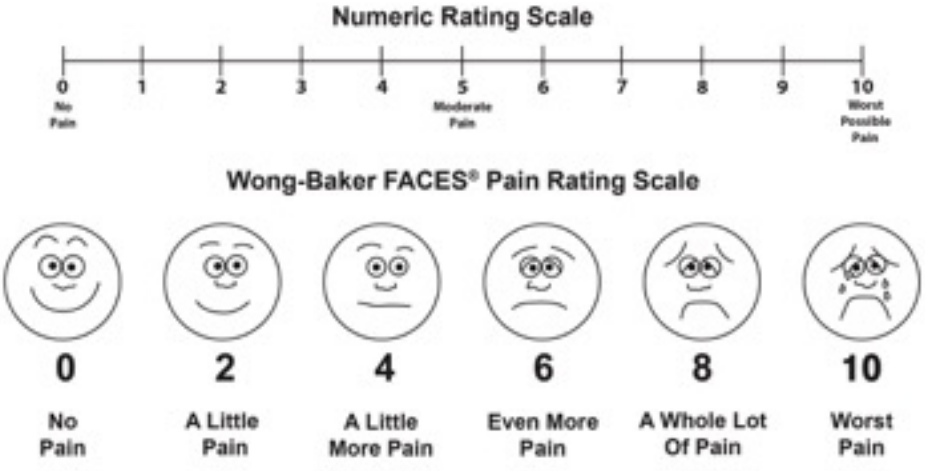
Please indicate below where your symptoms are located:



KEY

Numbness =======
Pins and Needles 00000000
Burning Pain XXXXX
Stabbing Pain ///////////////

If you are having pain, please rate the intensity of your pain on the scale below:



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# CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to Allied Health Solutions, LLC. My treatment plan has been explained to me by the treating physical therapist. I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have this facility provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature _____ Date _____

Signature of Parent / Guardian_____ Date _____