BACK TO BALANCE
Physical Therapy

Name: _____ DOB: _____/_____/_____

Height: _____ Weight: _____

## Medical History

| | | | |
|---|---|---|---|
| | Allergies | | Fractures |
| | Anemia | | Gallbladder Problems |
| | Anxiety | | Hepatitis |
| | Arthritis | | High Blood Pressure |
| | Asthma | | Incontinence |
| | Cancer | | Kidney Problems |
| | Cardiac Condition | | Metal Implants |
| | Cardiac Pacemaker | | Multiple Sclerosis |
| | Chemical Dependency | | Osteoporosis |
| | Circulation problems | | Osteoarthritis |
| | Currently Pregnant | | Rheumatoid Arthritis |
| | Diabetes | | Parkinson's Disease |
| | Vertigo/Dizziness | | Seizure disorder |
| | Emphysema/Bronchitis | | Stroke |
| | Fibromyalgia | | Vision or Hearing impaired (circle one or both) |

Describe any other conditions or precautions: _____

_____

_____

_____

**History of Falls:**

Have you had a fall in the past 6 months? Yes / No Date of Fall: _____

Were you injured as a result of the fall? Yes / No If yes, describe: _____

**Surgical History**

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

**Please list all Medications:** _____

_____