ENCHANTED LAKE PHYSICAL THERAPY

MEDICAL HISTORY

Current Medications (including non-prescription): _____

_____

Previous hospitalization/surgeries/serious illness (list & date): _____

_____

Are you currently working? □ Yes □ No If No, last day worked:_____Return to work date: _____
If Yes, working □ Full Duty □ Light Duty Restrictions:_____Hours working: _____

Have you ever been diagnosed for any of the following conditions (check all that apply):

□ Aids/HIV
□ Cancer
□ Diabetes
□ Respiratory/Lung Problems
□ Kidney/Liver Problems
□ Bladder Problems
□ Heart Conditions (Angina, etc.)
□ Orthopedic (Fracture, arthritis, etc.)
□ Osteoporosis
□ Metal Implants
□ Fibromyalgia
□ Muscular Dystrophy
□ Deep Vein Thrombosis
□ Gout
□ Headaches
□ Neurological Conditions (Seizures, MS, Parkinson's, etc.)
□ Anxiety/Depression
□ Allergies (Heat, Cold, Skin etc.)
□ High Blood Pressure
□ Other: _____

Have you had a recent illness or medical condition noted above that would be affected by physical activity (if yes, explain)?

_____

Do you have medical clearance? □ Yes □ No Do you take blood thinners? □ Yes □ No
Are you allergic to latex? □ Yes □ No Other allergies (please list): _____
Females: Are you pregnant? □ Yes □ No If yes, due date: _____ Do you smoke? □ Yes □ No

Currently I am experiencing (check all that apply):

Fever/chills/sweat ☐ Poor Balance (falls) ☐ Unexplained weight loss ☐ Depression ☐
Numbness/Tingling ☐ Changes in Appetite ☐ Difficulty Swallowing ☐ Headaches ☐
Shortness of Breath ☐ Dizziness ☐ Nausea/Vomiting ☐
Increased pain at night ☐ Changes in bowel or bladder function ☐

COVID Screening:

Do you have a fever (100.4° or greater) or have you felt feverish over the past 2 weeks? ☐ Yes ☐ No

Are you experiencing shortness of breath or difficulty breathing? ☐ Yes ☐ No

Do you have a dry or persistent cough? ☐ Yes ☐ No

Do you have any other flu-like symptoms, such as sore throat, upset stomach, headache, fatigue, or muscle aches/pain? ☐ Yes ☐ No

Have you experienced recent loss of taste or smell? ☐ Yes ☐ No

Have you ever been exposed or are you in close contact with any confirmed COVID-19 positive patients? (*Patients who are well but who have a sick family member at home with COVID-19 need to reschedule their appointment.)* ☐ Yes ☐ No
If yes, please note date of exposure:_____

Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders? ☐ Yes ☐ No

Have you or anyone in your household traveled out of state in the past 5 days? ☐ Yes ☐ No

To the best of my knowledge, this information is correct and accurate.

_____ _____ _____
Patient/Parent/Guardian Signature Relationship to Patient Date