

INTEGRITY THERAPY GROUP - HEALTH HISTORY

Patient Name: _____ Date: _____

Date of Next Physician Appt: _____

1. Please check if you have or have ever had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis/gout | <input type="checkbox"/> Abnormal EKG/Stress Test | <input type="checkbox"/> Infectious disease
(eg, tuberculosis) |
| <input type="checkbox"/> Joint or bone Surgery/fractures | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Low blood sugar/hypoglycemia | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Metal implants | <input type="checkbox"/> Diabetes/high blood sugar | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Loss of balance/falls | <input type="checkbox"/> Stroke | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Mesothelioma | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Lung disease or shortness
of breath | <input type="checkbox"/> Dizziness or blackouts |
| <input type="checkbox"/> Neurological problems
(Parkinsons, Multiple Sclerosis, etc.) | <input type="checkbox"/> Lung problems
(specify _____) | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Back problems requiring
Medical attention | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Developmental or growth problems | <input type="checkbox"/> If Female: current pregnancy | <input type="checkbox"/> If Child: current with
immunizations |

Please explain any box checked above: _____

2. Have you ever had surgery? Yes No If yes, please describe and include dates: _____

3. List any allergies, including medications: _____

4. Have you had any testing done recently (x-rays, MRI, blood tests, etc)? If so, what tests & where did you
Receive test? _____

5. Do you have any sores that have not healed or any changes in size, shape, or color of a wart or mole? _____

6. Do you smoke? _____ If so, how much? _____

7. Please describe the problem(s) for which you seek physical therapy _____

Comment _____

I have read and completed this form to best of my knowledge:

Signature

Date

