WILBER PHYSICAL THERAPY LLC

209 W. 3rd St. Wilber, NE 68465
Phone (402) 821.3320 Fax (402) 821.2177

PATIENT MEDICAL HISTORY

Please check all that apply to your current injury:

____ Alcohol abuse problems
____ Angina
____ Arthritis
____ Back Injuries
____ Cancer
____ Circulatory Problems
____ Dislocation of Joints
____ Fractures (broken bones)
____ Heart Attacks
____ Heart Disease
____ Heart Surgery
____ High blood pressure
____ Stroke
____ TMJ/ Jaw injuries
____ Whiplash
____ Allergies
____ Diabetes
____ Epilepsy/Seizures
____ Joint strains
____ Gastrointestinal problems
____ Gout
____ Emotional problems
____ Lung Disease
____ Nervous Problems
____ Osteoporosis
____ Tumors
____ Neck Injuries
____ Muscle strains
____ Kidney Disease

CHECK THE FOLLOWING BOXES IF YOU HAVE RECENTLY EXPERIENCED

____ Headaches
____ Muscular pain with exertion
____ Falls
____ Tremors
____ Muscular pain at rest
____ Difficulty sleeping
____ Constant Pain unrelieved by rest / movement
____ Hoarseness
____ Change in bowel/ bladder habits
____ Shortness of breath
____ Dizziness
____ Balance problems
____ Unusual fatigue
____ Unusual weakness
____ Blurred/double vision
____ Tingling, numbness/loss of feeling
____ Unusual skin coloration
____ Pain with coughing/sneezing
____ Unexplained weight loss

PLEASE LIST ANY MAJOR SURGERIES OR HOSPITALIZATIONS

________________________________ DATE: ________________
________________________________ DATE: ________________

DO YOU SMOKE? YES/NO IF YES, HOW MANY PER DAY? ARE YOU PREGNANT? YES/NO

ARE YOU ALLERGIC TO ANY MEDICATION? YES/NO. IF YES, PLEASE LIST MEDICATIONS.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

____
____

I, UNDERSTAND, STATE THAT I HAVE ANSWERED THIS QUESTIONNAIRE TO THE BEST OF MY KNOWLEDGE.

Signature: ________________________________ **DATE:** ________________

Treating Therapist's Signature: ____________________ **DATE:** ________________