LAKE RIDGE PHYSICAL THERAPY, LLC
(dba Fusion Physical Therapy)

PATIENT HEALTH HISTORY

Name: _____ Date of Birth: _____, Age:_____ Date: _____

Describe present symptoms:

_____

On a scale of 0 - 10 (0 = No Pain, 10 = Severe Pain) how would you rate your pain today? _____

Allergies: ☐ Seasonal ☐ Peanuts ☐ Tree Nuts ☐ Other: _____

Past Medical History: *Check all current and previous conditions*.

☐ High Blood Pressure	☐ Kidney Disease / Problems	☐ Shortness of Breath	☐ Heartburn / Acid reflux
☐ Low Blood Pressure	☐ Heart Attacks	☐ Asthma	☐ Ulcers / Colitis
☐ High Cholesterol	☐ Heart Arrhythmias	☐ Sinus Problems	☐ Neurological Issues
☐ Liver Disease	☐ Heart Failure	☐ Persistent Cough	☐ Vision Problems
☐ Diabetes	☐ Mitral Valve Prolapse	☐ Headaches / Migraines	☐ Hearing Problems
☐ Cancer	☐ Pacemaker	☐ Bowel / Bladder Irregularities	☐ Psychiatric Care
☐ Osteoporosis	☐ Epilepsy / Seizures	☐ Hepatitis _____	☐ Depression / Anxiety
☐ Thyroid Issues	☐ Stroke	☐ Dizziness	☐ Other (list below):

_____

_____

Please describe any current or past medical history not listed above:

_____

_____

Please list **ALL** hospitalizations or past surgeries along with surgical **dates**:

_____

_____

_____

Please list any medications or supplements you are currently taking along with the dosage (include vitamins and herbal):

_____

_____

_____

_____

Social & Preventative History:

Do you currently use any tobacco products?	Yes	No	If yes, how often?
Do you drink alcoholic beverages?	Yes	No	If yes, how often?
Do you exercise / engage in physical activity?	Yes	No	If yes, how often?

By signing, I herby certify that all the information provided in this document is accurate and true, to the best of my knowledge.

_____ _____

Patient / Guardian Signature **Date**