

**General Medical Form**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Briefly describe your condition \_\_\_\_\_  
\_\_\_\_\_

When did your condition begin? \_\_\_\_\_

When was your most recent doctor's appointment? \_\_\_\_\_

Is your condition a result of an event such as a fall or car accident?      Yes    No

Is your condition resulting in a workmen's compensation claim?      Yes    No

If yes for either, please explain. \_\_\_\_\_  
\_\_\_\_\_

Is a lawyer involved?    Yes    No

Have you had this condition in the past?    Yes    No

Have you had any other treatment for this condition (currently or in the past)    Yes    No

If yes, please check:

\_\_\_ Surgery

\_\_\_ Chiropractic care

\_\_\_ CT scan

\_\_\_ Medications

\_\_\_ Physical therapy

\_\_\_ MRI

\_\_\_ Injections

\_\_\_ X-rays

\_\_\_ EMG/ NCV

\_\_\_ Other: \_\_\_\_\_

Have you had physical therapy for this or any other condition in the last year? If so, please list approximate dates and cause for services. \_\_\_\_\_  
\_\_\_\_\_

Please list all current prescription medications that you are taking for any condition. \_\_\_\_\_  
\_\_\_\_\_

Please list all prior surgeries. \_\_\_\_\_

Please list all allergies. \_\_\_\_\_

What are your goals for physical therapy? \_\_\_\_\_