

# Lighthouse Physical Therapy

## ***PATIENT INFORMATION***

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Provider's Phone #: \_\_\_\_\_

## ***MEDICAL HISTORY***

### ***General***

Are you currently taking any medications? If so, please list them here: Y N

Do you have any allergies to foods and/or medications? If so, please list them here: Y N

Have you had any major illnesses/accidents/injuries? If so, list them here: Y N

Have you ever had any surgery? If so, please list here: Y N

Have you ever have any problems with heat (stroke, exhaustion, etc.) and/or cold? Y N

Do you have frequent nausea and/or vomiting? (Circle the appropriate response) Y N

Do you have constipation, diarrhea, irritable bowel syndrom and/or acid reflux? (Circle) Y N

Do you have hemophilia or a bleeding disorder? (Circle) Y N

Do you have diabetes? Y N

Do you have anemia? Y N

Do you have high blood pressure, high cholesterol or any heart conditions? (Circle) Y N

Have you ever been advised by a medical doctor not to participate in any athletic activity? Y N

Do you have missing body parts (eye, kidney, hysterectomy, gallbladder, etc.)? Y N

Do you have any bladder issues or urinary incontinence/urgency? (Circle) Y N

### ***Eyes***

Do you have poor vision in either eye? Y N

Do you wear glasses or contacts? (Circle the appropriate response) Y N

Have you had any eye surgery? Y N

### ***Chest/Pulmonary***

Have you ever had pneumonia? Y N

Do you have asthma? Y N

Are you frequently short of breath? Y N

Do you ever wheeze? Y N

Do you have frequent and/or chronic cough? Y N

Do you have any pain with coughing and/or holding your breath? (Circle) Y N

**Neurological**

Do you have occasional dizziness?	Y	N
Do you ever faint?	Y	N
Do you get frequent or severe headaches? (Circle)	Y	N
Have you ever had a concussion, or a loss of consciousness? (Circle)	Y	N
Have you ever had a neck injury?	Y	N
Have you ever had seizures or epilepsy? If yes, give date of most recent seizure:	Y	N
Do you have numbness, tingling and/or radiating pain in your arms and/or legs? (Circle)	Y	N

**Orthopedic**

Have you ever had any fractures/broken bones? If so, list them here:	Y	N
Have you ever had a shoulder separation or dislocation? (Circle the appropriate response)	Y	N
Do you get chronic shoulder pain?	Y	N
Have you ever been told that you have bursitis or tendonitis in you shoulder? (Circle)	Y	N
Have you ever had an elbow dislocation?	Y	N
Do you get chronic elbow pain?	Y	N
Do you get chronic wrist pain?	Y	N
Do you have chronic back pain?	Y	N
Do you have scoliosis?	Y	N
Do you have spondylolysis (stress fracture of the low back) or spondylolisthesis?	Y	N
Have you had occasional hamstring muscle strains/pulls?	Y	N
Do you get chronic knee pain?	Y	N
Have you had tendonitis of the knee?	Y	N
Has anyone ever told you that you have Osgood-Schlatter's disease?	Y	N
Have you ever had a cartilage tear in the knee?	Y	N
Have you ever had a ligament sprain/injury in the knee?	Y	N
Has your patella (kneecap) ever dislocated?	Y	N
Have you ever had shin splints or a stress fracture in your leg? (Circle)	Y	N
Have you had Achilles tendonitis?	Y	N
Do you get frequent ankle sprains?	Y	N
Do you have bunions that hurt?	Y	N
Are there any other physical or mental situations that the attending therapist should be aware of in determining this individual's readiness to participate in daily work/home activities, sports, etc. If yes, please explain here:		
How did you hear about Lighthouse Physical Therapy?		
_____	_____	
Patient's Signature Parent/Guardian if under 18	Date	