Advance Physical &

Aquatic Therapy

Patient Name:	Date of Birth:
Reason for Therapy:	Date of injury onset:
Have you ever received therapy for the condition mentioned above? ⬜ Yes ⬜ No	If so, when?:
Treatment Received:	Previous Treatment: ⬜ Successful ⬜ Unsuccessful

Do you now or have you ever had any of the following? (Please check each box that pertains to you)

Condition	**Y**	**Condition**	**Y**	**Condition**	**Y**
Thyroid Problems		Arthritis		Diabetes	
Headaches		Osteoporosis		Anemia	
Head Injury/Concussion		High Blood Pressure		Hypersensitivity to Heat/Cold	
Hernia		Heart Disease		Swelling in Ankles	
Kidney/Bladder Problems		Heart Attack		Deep Vein Thrombosis	
Previous Surgeries		Pacemaker		Seizures/Epilepsy	
Hearing Loss		Vascular Disease		Metal in Body or Surgical Implants	
Depression		Stroke		Cancer/Tumor	
Anxiety		Asthma		Current Infection(s)	
Substance Abuse		Shortness of Breath		Tuberculosis	
Alcohol Abuse		Recent Weight Loss/Gain		Hepatitis	
Tobacco Use		Chronic Cough		Fainting Spells	
				Other:	

If you answered "yes" on any of the above, please explain and give approximate date(s):

If you answered "yes" to Tobacco Use, would you be interested in learning more about smoking cessation?
⬜ Yes ⬜ No

Do you have any allergies? ⬜ Yes ⬜ No. If yes, please list allergies:

Are you presently taking any medications? ⬜ Yes ⬜ No. If yes, please list and specify conditions.

The information is correct to the best of my knowledge and I give my consent to receive treatment at Advance

X

Patient/Parent/Guardian Signature	Date

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