Patient Medical History

First Name:	Last Name:	Middle Initial:
Referring Physician:	Family Physician:	
Have you had surgery for this injury? Yes No	Type of Surgery:	
Number of surgeries for this injury:	Is an attorney involved in this case? Yes No	

Height:	Weight:	Age:	Do you have a living will? Yes No

Do you have or ever had any of the following:					
	YES	NO		YES	NO
Lung/Breathing problems			Heart Condition		
Do you have a pacemaker?			High Blood Pressure		
Blood clot/emboli			Epilepsy/seizures		
Infectious disease			Diabetes		
Cancer			Arthritis/swollen joints		
Osteoporosis			Allergy to latex		
Any joint/metal implants			Dizziness		

Gulf Coast Therapy may provide my medical information upon request to:

Name	Phone Number	Relationship to Patient

I do not wish to authorize access to my medical information to anyone. ☐

Please list any other information that would assist us in your care:_____

_____

_____

_____

Patient/Responsible Party Signature: Date:

Therapist Signature: Date: