Sport Summit Physical Therapy

New Patient Health History

Name: _____ Date: _____

Referring physician: _____ Specialty: _____

Primary care provider (if different from above): _____

Reason for referral: _____ Date of onset: _____

Past medical history/chronic medical problems: _____
_____
_____

Previous surgeries: _____
_____
_____

Current medications: _____
_____
_____

Medication allergies: _____
_____
Do you have an allergy/sensitivity to latex? Yes _____ No _____

Please check if you have a history of any of the following:
MRSA/staph infection: _____ Hepatitis: _____ HIV/AIDS: _____ TB: _____
What treatment have you had for the above? _____

Currently pregnant? No _____ Yes _____ If yes, name of OBGYN: _____

Your personal therapy goal(s): _____
_____
_____

I authorize that the above information is true and current to the best of my knowledge. I will notify Sport Summit Physical Therapy of any changes in my health status or any of the above information.

Signature of Patient or Guardian: _____ Date: _____