Action Potential
One on One Physical Therapy

_____ _____
Client Name Date of Birth

_____ _____
Referring Physician Primary Care Physician

_____
Email

Past Medical History:

□Alzheimer's	□Fibromyalgia	□Parkinson's
□Cardiovascular Disease	□Fracture	□Rheumatoid Arthritis
□Coronary Artery Bypass	□High Blood Pressure	□Brain Injury
□Heart Attack	□History of Cancer	□COPD/Emphysema
□Pacemaker	□Huntington's	□Asthma
□Cauda Equina Syndrome	□Immunosuppression	□Osteoporosis
□Stroke/TIA	□Lupus	□Cataracts
□Current Infection	□Muscular Dystrophy	□Amputation
□Diabetes Mellitus Type I	□Obesity	□Anxiety
□Diabetes Mellitus Type II	□Osteoarthritis	□Depression
□Diabetic Neuropathy		

□Other: _____

□Surgeries: _____

□Recent Falls: YES NO Explain:_____

At the present time would you say that your health is:

□excellent □very good □fair □poor

Please rate your current pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

therapist initial: _____ date: _____

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Medication List: Please list all prescription and over the counter medications, vitamins, supplements. Include dose, frequency, and route
If you already have a current list, we are happy to make a photocopy

Name	Dose	Frequency	Route (oral, injection, etc.)

therapist initial: _____ date: _____