

Action Potential

One on One Physical Therapy

Client Name _____

Date of Birth _____

Referring Physician _____

Primary Care Physician _____

Email _____

Past Medical History:

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

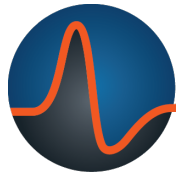
Please rate your current pain:

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: _____