ERA Physical Therapy

Informed Consent for Treatment

Medical History Form: Date:_____

Name:_____ Home phone:_____

Occupation:_____

Referred by:_____

For the following questions circle *yes* or *no.* Your answers are for our records only and will be considered confidential.

1) Are you in good health? . . . . . Yes No
2) Has there any change in your general health lately? . . . . . Yes No
3) Did you have a recent physical? . . . . . Yes No
4) Are you now under the care of a physician? . . . . . Yes No
   If yes, what is the condition treated?_____
5) Have you had any serious illness, operation or been hospitalized in the last 5 years? . . . Yes No
   If yes, what is the condition treated?_____
6) Are you taking any medications including over the counter?
   If yes, which?_____
7) Do you have or had any of the following problems?
   YN

a.	Cardiovascular problem: high blood pressure, CHF N, Y:
i.	Do you have chest pain upon exertion? N, Y:
ii.	Are you short of breath after mild exercise or when lying down? N, Y:
iii.	Do your ankles swell? N, Y:
iv.	Do you have pacemaker? N, Y:
b.	Heart diseases including: murmur, valve damage, artificial heart valve, rheumatic heart disease. N, Y:
c.	Allergy (medications, latex etc.) N, Y:
d.	Sinus troubles N, Y:
e.	Asthma or hay fever N, Y:
f.	Fainting spells or seizures N, Y:
g.	Persistence diarrhea or recent weight loss N, Y:
h.	Diabetes N, Y:
i.	Hepatitis, Jaundice or liver disease N, Y:
j.	AIDS N, Y:
k.	Thyroid problems N, Y:
l.	Respiratory problems, emphysema, bronchitis, etc. N, Y:
m.	Arthritis or swollen joints N, Y:
n.	Stomach ulcer or hyperactivity N, Y:
o.	Kidney trouble N, Y:
p.	Tuberculosis N, Y:
q.	Persistence cough N, Y:
r.	Low blood pressure N, Y:
s.	Sexually transmitted disease N, Y:
t.	Epilepsy N, Y:
u.	Neurological N, Y:
v.	Mental health (depression, etc.) N, Y:
w.	Cancer? Over 5 years? N, Y:
x.	Have you had abdominal bleeding? N, Y:
y.	Do you suffer from anemia? Vasovagal reactions? N, Y:
z.	Do you wear glasses? Contacts?

8) Woman:
   a. Are you pregnant?
   b. Are you trying to get pregnant?

Patient signature:_____ Clinician signature: _____Date:_____