Hudson Valley Manual Physical Therapy

Patient Medical History

Name (Last):_____ (First)_____Date of Birth:_____

Medical Information

Current Doctors: ☐ None ☐ List:_____
_____
_____

Medications: ☐ None ☐ List:_____
_____
_____

General Health Problems: ☐ None ☐ List:_____
_____
_____

Surgeries/Hospitalizations: ☐ None ☐ List:_____
_____
_____

Reason for coming to Physical Therapy

Trauma: ☐ Yes ☐ No ☐ Describe:
_____
_____

Gradual Onset: ☐ Yes ☐ No ☐ Describe:
_____
_____

Previous Episodes: ☐ Yes ☐ No ☐ Describe:
_____
_____

Previous Treatment for this condition: ☐ Yes ☐ No ☐ Dates of Treatment:_____
Describe Treatment:_____
_____

Hobbies/Sports/etc.:_____
Workout Program: ☐ None ☐ List:
_____
_____

How did you hear about this office?:_____
Name of doctor who referred you to my office:_____

Patient Signature:_____ Date:_____