HULST JEPSEN
PHYSICAL THERAPY

Past Medical History

Name: _____

Date of injury/onset/surgery:_____

Current Complaint: _____

Please check if you have/had any of the following:

	Diabetes		Migraines		Seizures
	Chest Pain		Bowel/urinary changes		Dizziness/Fainting
	High Blood Pressure		Lung/Breathing difficulties		Fractures
	Stroke		Current/Recent pregnancy		Hernia
	Heart Attack		Osteoporosis		Cancer
	Heart Palpitations		Falls in the past 12 months		Night Pain
	Pacemaker		Arthritis		Anxiety/Depression

Previous Surgeries: _____

Are you allergic to latex? (check one): ☐ **YES** ☐ **NO**

Current Medications:

- ○ Prescriptions
- ○ Over the Counter

List of Medications:

_____

_____

Rate the intensity of your pain/symptoms, from 0 (no pain) to 10 (worst pain possible):

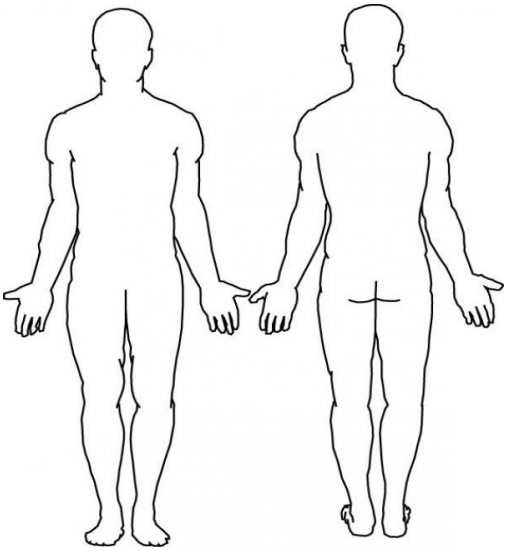
Current:

At Worst:

At Best:

Pain Description: _____

_____



Mark location of symptoms with an X on diagram