ZENERGY
Physical Therapy

Medical History

Full Name: _____

DOB:_____

PLEASE LIST ALL SIGNIFICANT INFORMATION PERTAINING TO TODAY'S VISIT

Do you currently have or ever had any of the following? (Please check all that apply).

YES	CONDITION:
☐	Allergies
☐	Angina/Heart Problems
☐	Osteoporosis
☐	Back Injury/Surgery
☐	Do you have a pacemaker?
☐	Red, Hot or Swollen Joints
☐	Diabetes
☐	Difficulty Walking
☐	Heart Attack/Surgery
☐	Chemo/Radiation Therapy
☐	Epilepsy/Seizures
☐	Fainting
☐	Metal Implants
☐	Vision or hearing problems
☐	Skin Diseases
☐	Asthma or Emphysema
☐	Arthritis
☐	Unexpected Weight Loss
☐	Neck Injury/surgery
☐	Are you pregnant?
☐	Bowel/Bladder Problems
☐	Cancer
☐	Stroke
☐	Dizziness/Vertigo/Loss of Balance
☐	Headaches/ Migraines
☐	Infectious Disease
☐	Tingling or Numbness
☐	Psychological Problems

List All Current Medication(s):

_____
_____
_____
_____
_____
_____

List Major Surgeries and Hospitalizations:

Date: _____
Surgery: _____

Date: _____
Surgery: _____

Date: _____
Surgery: _____

Date: _____
Surgery: _____

Known Allergies: _____

_____
_____
_____
_____
_____
_____