



Life Strength Physical Therapy, Inc.
110 West Road, Suite 105
Towson, MD 21204
Phone 410-321-4901

Medical Questionnaire

Name: _____ Date: _____

Medical History (circle all that apply)

- | | | |
|------------------------|-----------------------|--------------------|
| AIDS or HIV | Headaches | Pacemaker |
| Allergies | Heart Condition | Pregnant |
| Artificial Joint _____ | High Blood Pressure | Prostate Condition |
| Blackout episodes | Hypothyroid Condition | Radiation Therapy |
| Cancer | Incontinence | Seizure Disorder |
| Circulatory Condition | Kidney Failure | Stroke or TIA |
| Diabetes | Long Term Steroid Use | TMJ Dysfunction |
| Dizziness | Low Blood Pressure | Vertigo |
| Fractures _____ | Metal Implant | Visual Impairment |

Reason(s) for which you are seeking Physical Therapy treatment:

List all prior surgeries:

List all current medications:

List all special tests that have been performed for your condition (i.e. X-ray, MRI, CT Scan):

List all prior physical therapy, chiropractic or osteopathic treatment for this condition:

The information I have provided is correct to the best of my knowledge.

Signature

Date