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 even if medically controlled)

AIDS or HIV	Dizziness/Vertigo	Incontinence	Parkinson's
Allergies	Fractures__________	Kidney Failure	Pregnant
Artificial Joint _______	Headaches	Long Term Steroid Use	Radiation Therapy
Blackout Episodes	Heart Condition	Low Blood Pressure	Seizure Disorder
Cancer	High Blood Pressure	Metal Implant	Stroke or TIA
Circulatory Condition	Hyperthyroid	Osteoporosis	TMJ Dysfunction
Diabetes	Hypothyroid	Pacemaker	Visual Impairment

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

List all prior surgeries:

List all current medications:

DRUG NAME	DOSAGE	FREQUENCY AND ROUTE
Example: Aspirin	*81 mg*	*One pill a day by mouth*

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