Health History

1. Have you had physical therapy elsewhere in this calendar year? ☐YES ☐NO

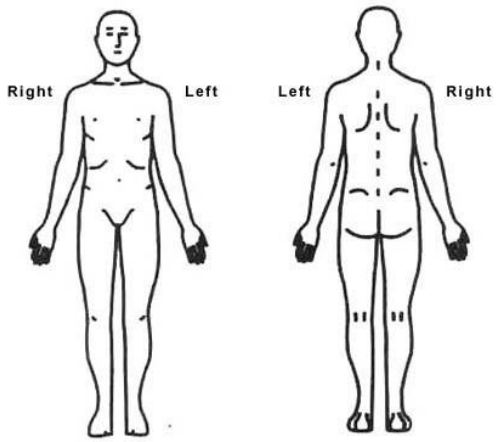
2. Are you presently under any medical treatment, other than physical therapy? ☐YES ☐NO
   If yes, explain:_____

3. Do you now or have you ever had an allergy to any of the following?
   I Do Not Have Any Allergies: ☐

   ☐Cold Application ☐Heat Application
   ☐Petroleum Products ☐Adhesive Tape
   ☐Latex/Rubber
   ☐Drugs/Medications
   Please list: _____
   _____

4. Do you have pain ***TODAY***?

Where is your PAIN? (Please circle)



Emergency Contact Information

Name:_____

Phone #: _____ Relation to patient: _____

Patient Name: _____