MAKE the CONNECTION, LLC
Physical Therapy & Muscle Activation Techniques

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Medical History Form

First Name | Last Name | M. I.

Sex | Date

In order for us to be more effective and specific with your treatment, we require that all sections below be filled out as completely as possible (even if you feel the information is non-applicable).

PATIENT INFORMATION

What are your current symptoms? What brought you here today?

Please list all injuries/accidents below

Date	Type of Injury (sports, fracture, whiplash, falls, torn ligaments, etc)

Please list all medical/structural diagnosis below

Date	Type of Diagnosis (scoliosos, Lupus, etc)

Please list all treatments below

Date	Type of treatment (phys. therapy, massage, chiropractic, etc.)	(please circle result)
		better same worse
		better same worse
		better same worse
		better same worse

How many children/pregnancies? (female patients only)

Date	Type of birth (natural, c-section)

Please list all surgeries below

Date	Procedure

Please list all external braces below

Date	Diagnosis (orthotics, dental splints, etc.)

Please list all applicable family history information below

Condition	Relationship	Age Developed, Diagnosis
Cancers		
Cardiovascular		
Diabetes		
Arthritis		
Other		

Please list all medications below

Medication	Condition

Please list all hormones below

Medication (Insulin, Premarin, etc.)	Condition (post-menopause, etc.)