

**BLASER PHYSICAL THERAPY**  
**PATIENT HEALTH HISTORY SCREENING**

FULL NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Please describe your injury/symptoms which required you to come to Blaser Physical Therapy. If accident related (work/automobile/other) please give details: \_\_\_\_\_

FUNCTIONAL LIMITATIONS DUE TO INJURY: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

WERE X-RAYS TAKEN? YES \_\_\_ NO \_\_\_ WHERE? \_\_\_\_\_

WERE MRI'S PERFORMED? YES \_\_\_ NO \_\_\_ WHERE? \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

PREVIOUS MEDICAL HISTORY: CHECK ALL THAT APPLY

- |                                     |                                   |
|-------------------------------------|-----------------------------------|
| _____ Vision Impairment             | _____ Pregnant (at this time)     |
| _____ Hearing Difficulties          | _____ Shingles                    |
| _____ Arthritis/Bone problems       | _____ Previous Surgeries          |
| _____ Speech Impairment             | _____ Back Problems               |
| _____ Fainting/Dizzy Spells         | _____ Stomach Ulcers              |
| _____ Epilepsy/Convulsions/Seizures | _____ Hernia                      |
| _____ Allergies/Wheezing/Asthma     | _____ Bowel Problems/Difficulties |
| _____ Shortness of breath           | _____ Menstruation problems       |
| _____ TB                            | _____ Metal Implants              |
| _____ Pacemaker                     | _____ Diabetes/Insulin Dependent  |
| _____ Chest Pain/Pressure           | _____ Kidney Problems             |
| _____ Heart Problems                | _____ Skin allergies/Disease      |
| _____ Varicose Veins                | _____ Alcoholism/Drug Addiction   |
| _____ Circulatory Problems          | _____ Mental Health Problems      |
| _____ HIV/AIDES                     | _____ Cancer                      |
| _____ Hepatitis (Type?)             | _____ High Blood Pressure         |
| _____ Blood Transfusions            | _____ Low Blood Pressure          |
| _____ MRSA                          | _____ Thyroid                     |

Please provide a brief description for each item checked above. Use the back of this page if needed.

Are you aware of any precautions for each item checked above? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe: \_\_\_\_\_

**AUTHORIZATION OF TREATMENT**

I hereby authorize the staff of Blaser Physical Therapy, Inc. to evaluate and perform the treatment plan, which my physician has prescribed.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian Date