Pioneer Therapy Center

Medical History Information

Client Name_____ Today's Date _____

Referring Physician _____ Phone _____

Reason for Therapy _____

Date of onset/injury/surgery_____

Have you had previous therapy for your present condition for which you will receive treatment here?

Yes ( ) No ( )

If yes, please state where and what treatment was given _____

_____

Do you now have or have you ever had any of the following?

Diabetes ____	High Blood Pressure ____	Heart Disease/Attack ____
Pacemaker ____	TMJ Disorders ____	Headaches ____
Kidney Disorders ____	Nervous Disorders ____	Circulatory Disorders ____
Pulmonary Disorders ____	Asthma ____	Depression/Emotional ____
Tobacco use ____	Sensitivity to heat/ice ____	Other Allergies ____
Orthopedic concerns ____	Metal Implants ____	Previous Surgery ____
Hernia ____	Pregnancy ____	Cancer ____
Dizziness/Blurred vision ____	Seizures ____	Motor Vehicle Accidents ____
Forgetfulness ____	Other Illnesses ____	

If YES on any of the above, place explain and give approximate date.

_____

_____

Are you presently taking any medications? Yes ( ) No ( ). If yes, please list name and for what condition.

_____

_____

The Undersigned acknowledges and agrees that the above information is true and correct.

Date_____ Print Name _____

Signature _____

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