Pioneer Therapy Center

Medical History Information

Client Name _____ Today's Date_____

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, please explain and give approximate date.

_____

_____

_____

_____

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

_____

_____

_____

_____

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

Date_____ **Print Name** _____

Signature_____

324 E Pioneer, Puyallup, WA 98372

P: 253.377.6285 | F: 253.639.2016