Farm to Treatment Table Patient Medical History

Do you have, or have you had, any of the following? Please check **ALL** that apply.
Leave blank to indicate you **DON'T** have this condition

___High blood pressure
___Heart problems
___Shortness of breath
___Changes in hair or nails
___Diabetes
___Low blood sugar
___Thyroid problems
___Difficulty sleeping while lying flat
___Lung problems
___Asthma
___Ulcers
___Cancer
___Night sweats
___Nausea, vomiting
___Bleeding or bruising
___Tumors
___Lumps, bumps
___Unexpected weight gain/loss in last 6 Months
___Long term steroid use
___Osteoporosis
___Head Trauma/Stoke/TIA
___Loss of consciousness/fainting/blackouts
___Change in vision
___Dizziness
___Balance problems
___Ringing in ears
___Major dental work
___Difficulty eating
___Difficulty swallowing
___Abuse
___Change in ability to taste food
___Vocal changes
___Ear pain
___Headaches
___Mental illness
___Numbness tingling
___Arthritis
___Muscle cramps
___Broken bones in last year
___Surgery related to the problem we are seeing you for
___Varicose veins
___Hot or cold intolerance
___Productive coughing
___Any contagious diseases
___Rashes
___Fever
___Bowel or bladder changes
___Pelvic inflammatory disease
___Difficulty urinating
___Blood in urine
___Bladder, kidney infection
___Abnormal or painful menstruation
___Incontinence
___Currently pregnant
___Do you smoke? (Y/N)
___Do you drink alcohol? (how often?)
___Do you exercise (how many times/week?)_____

Medications:_____
_____

Comments or things we should know about you:_____
_____

Have you had physical therapy for this condition? Y N

Please take a moment to carefully read the information and sign where indicated. If you have a specific medical condition or specific symptoms, physical therapy may be contraindicated. A referral from your primary care provider may be required prior to service being rendered. I understand that physical therapy should not be construed as a substitute for medical examination or diagnosis and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. Because physical therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Patient Name:_____ Date of Birth:_____