Physical Therapy & Vestibular Rehabilitation

Wendy Webb Schoenewald, PT, OCS
Kelsey Hanlon, PT, DPT
Palak Mulji, PT, DPT
Joanne Haug, PT, DPT
Jenna McLane, PT, DPT
Amanda Nguyen, PT, DPT

Medical History

Name: _____ Age: _____ Date: _____

Height:_____ft___in__ **Weight:**_____lbs_

Please complete this form to the best of your ability. If you have any questions, please ask the receptionist.
Have you ever experienced any of the following *(mark in column Y for yes, N for no)*:

	Y	N		Y	N		Y	N
Bladder difficulties			Headaches			Osteoporosis/osteopenia		
Bowel difficulties			Heart disease			Recent fever		
Depression/anxiety			Hypertension			Seizures		
Diabetes			Lung disease			Smoker		
Dizziness			Obesity			Taking steroids		

	Y	N
Currently pregnant		
Cancer		
Circulatory disorder		

Where:_____
circle: upper / lower Extremities

Eye health/surgeries_____ *circle*: cataracts macular degeneration glaucoma

Provide Summary of Reason for Visit:_____
_____ Date of Injury:_____

Past medical history: _____
_____
_____

Previous therapy/surgeries/injuries: _____
_____

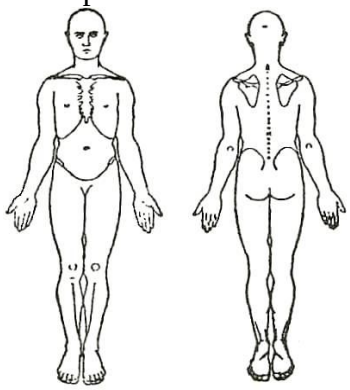
Diagnostic tests: _____
MRI: date: _____ location: _____

List all prescriptions, over-the-counters, herbals, vitamins and dietary supplements:

Name	Dosage	Frequency	Administration (oral, spray, injectable, etc.)

Rate your pain on a scale of 0 to 10: at rest _____ with activity _____

On the body chart below, please circle areas of pain and mark areas of numbness with an X.



1456 Ferry Road • Suite 601 • Doylestown, PA 18901 • (215) 489-3234 • Fax: (215) 489-0131 • www.wwspt.com