COASTAL REHAB
PHYSICAL THERAPY + SPORTS + SPINE

Health History

Name:	Height:	Weight:	Date:

How did this injury/exacerbation occur?

Have you had any diagnostic testing (x-ray, MRI, CT Scan, EMG, etc.)?

Medical History: Please check all that apply

- ☐ Pregnant
- ☐ Hypertension
- ☐ Stroke, TIA
- ☐ Circulatory Disease, Specify? ________________
- ☐ Heart Disease, Specify? ______________________
- ☐ Pacemaker
- ☐ Diabetic
- ☐ Cancer, Specify? ______________________
- ☐ Breathing Disorder, Specify? __________
- ☐ Headaches
- ☐ Allergies, Specify? ____________________
- ☐ Fall in the Past Year?

Please list any other Medical Conditions:

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Please list any Surgical Procedures and Dates if recent:

Type:	Date:	Type:	Date:

Please list any Medications you take with dosages, frequency, and route:

Medication:	Dosage:	Frequency (daily):	Route (oral, injection):

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