

**GRAYSLAKE REHABILITATION  
AND COMPLETE PHYSICAL THERAPY, LLC**

**MEDICAL HISTORY**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Why were you referred to physical therapy? \_\_\_\_\_

Please describe how your injury occurred: \_\_\_\_\_

Have you previously been treated for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what treatment did you receive? \_\_\_\_\_  
Where? \_\_\_\_\_

Have you received any special exams/tests related to this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list: \_\_\_\_\_

Do you have a history of: (Check all that apply)

<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer
<input type="checkbox"/> Respiratory Disorders	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Other _____

In the last five years have you been admitted to a hospital or have you undergone any surgical procedures? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what was the condition/treatment? \_\_\_\_\_

Please list all medications you are currently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

What type of physical activities do you participate in? \_\_\_\_\_

At the present time, what are the most difficult tasks for you to perform? \_\_\_\_\_

Are you now, or is there a chance that you may be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

**PATIENT'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**THERAPIST'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_