Peak Performance Therapy Center
519 Eureka Way • Sequim, WA • 98382
P (360)683-8331 • F (360)683-8441
PPTCUS.com

Therapist Initials:_____ Date:_____

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Medical History

Date: ________________________________Patient Name: ____________________________________ Age: _______________

Primary Care Provider (Physician): ____

Reason for referral to outpatient therapy:____

When did your symptoms start: ______________________ Are they improving? Worsening? Or Unchanging? __________________

Previous treatment for current condition that helped: ____

____

What 3 activities are you having the most difficulty with due to your current condition? 1) __________________________________

2)____ 3) ____

Recent Test Related to this Condition: If **Yes** Please write most recent date:

X-rays: ________ CT Scan: _________ MRI: __________Bone Scan: _________Bone Density: __________ NCS/EMG:__________

Current Medications	Dose	Reason for Medication
___________________________	_____________	_______________________________________
___________________________	_____________	_______________________________________
___________________________	_____________	_______________________________________
___________________________	_____________	_______________________________________

Allergies	Reaction
____	_______________________________________
____	_______________________________________

Do You Have a Latex Allergy? ☐ **Yes** ☐ **No**

Within the past 3 months, have you had:

A change in your health	☐ Yes	☐ No
Increase in fatigue	☐ Yes	☐ No
Difficulty Sleeping	☐ Yes	☐ No
Increased falling or loss of balance	☐ Yes	☐ No

Past Medical History

Surgeries	Year	Complications
___________________________	______________	_______________________________________
___________________________	______________	_______________________________________
___________________________	______________	_______________________________________

Social History

☐ Right Handed ☐ Left Handed

Smoke currently? ☐ Yes ☐ No

Previously smoked? ☐ Yes ☐ No

How long ago did you quit? ______ years

Recreational activities:____

Do you work? ☐ Yes ☐ No Occupation:____

Former occupation if retired: ____

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Medical History

Are you currently having problems or have you had any problems with the following?

	Yes	No	Describe all **Yes** responses		Yes	No	Describe all **Yes** responses
Bleeding Disorder	[ ]	[ ]	____________	Osteoarthritis	[ ]	[ ]	____________
Brain Injury	[ ]	[ ]	____________	Osteoporosis	[ ]	[ ]	____________
Diabetes	[ ]	[ ]	____________	Parkinson's disease	[ ]	[ ]	____________
Eyes, Ears, Nose, Throat	[ ]	[ ]	____________	Peripheral Neuropathy	[ ]	[ ]	____________
Fever	[ ]	[ ]	____________	Peripheral Vascular Disease	[ ]	[ ]	____________
Fibromyalgia	[ ]	[ ]	____________	Psychiatric	[ ]	[ ]	____________
Headaches	[ ]	[ ]	____________	Rheumatoid Arthritis	[ ]	[ ]	____________
Heart Disease	[ ]	[ ]	____________	Skin	[ ]	[ ]	____________
Heart Surgery	[ ]	[ ]	____________	Stroke	[ ]	[ ]	____________
Hepatitis	[ ]	[ ]	____________	Thyroid/Endocrine	[ ]	[ ]	____________
High Blood Pressure	[ ]	[ ]	____________	Tuberculosis	[ ]	[ ]	____________
High Cholesterol	[ ]	[ ]	____________	Urinary/Prostate	[ ]	[ ]	____________
HIV	[ ]	[ ]	____________	Weight Loss	[ ]	[ ]	____________
Immune System	[ ]	[ ]	____________		[ ]	[ ]	____________
Kidney Disease	[ ]	[ ]	____________	**Cancer**	[ ]	[ ]	____________
Lung Disease	[ ]	[ ]	____________	**Pacemaker/ Defribullator**	[ ]	[ ]	____________
MRSA	[ ]	[ ]	____________	**Pregnancy**	[ ]	[ ]	____________
Multiple Sclerosis	[ ]	[ ]	____________	**Seizure**	[ ]	[ ]	____________

Please List any **other** diagnosis or illness: ____

Patient Signature: ________________________________ Date: ____________________
(Initial Evaluation)

For Returning Patient Only:

Patient Signature: ________________________________ Date: ____________________

Patient Signature: ________________________________ Date: ____________________

Patient Signature: ________________________________ Date: ____________________