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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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: _____