FYZICAL™
Therapy & Balance Centers

9735 Southwest Highway
Oak Lawn, IL 60453
708-499-4497
www.fyzical.com/oaklawn

Medical History Intake Form

PATIENT INFORMATION

First Name: ____

Last Name: ____

Are you currently being treated by any health care professional in your home? Yes / No

ALLERGIES

List all medications you are allergic to: ____
Are you latex sensitive? Yes / No

List any other allergies we should know about:____

Have you declared the advanced clinical directive of Do Not Resuscitate? Yes / No

PRIOR TREATMENT/ DIAGNOSTIC TESTING

Have you recently received treatment for this problem? Yes / No
If so, please list treatment received (chiropractic, injections, etc.)___________________________

Have you had any diagnostic tests related to the problem you are seeking treatment for? Yes / No
If so, please list (MRI, X-rays, CT scan): ____

PAST MEDICAL HISTORY

Please circle any of the following that currently apply.

Yes	No	Weight loss/ gain	Yes	No	Weakness
Yes	No	Dizziness/lightheadedness	Yes	No	Tremors
Yes	No	Nausea/vomiting	Yes	No	Seizures
Yes	No	Constipation/diarrhea	Yes	No	Eye redness
Yes	No	Blood in stool/urine	Yes	No	Hearing problems
Yes	No	Easy bruising	Yes	No	Excessive bleeding
Yes	No	Regular cough	Yes	No	Arm/leg swelling
Yes	No	Difficulty swallowing	Yes	No	Loss of vision
Yes	No	Heart burn/indigestion	Yes	No	Stress at home/work
Yes	No	Heart racing in your chest	Yes	No	Pregnant or think you might be
Yes	No	Numbness/tingling	Yes	No	Skin rash
Yes	No	Fatigue	Yes	No	Fever/chills/night sweats
Yes	No	Problems sleeping	Yes	No	Joint/muscle swelling
Yes	No	Difficulty breathing	Yes	No	Urinary incontinence
Yes	No	Post menopause	Yes	No	Recent falls
Yes	No	Problems urinating	Yes	No	Pacemaker

Over

SURGERIES/HOSPITALIZATIONS

Please list any surgeries or conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date Surgery/Hospitalization

__________ ____

__________ ____

__________ ____

__________ ____

SIGNIFICANT INJURIES

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date Injury

__________ ____

__________ ____

__________ ____

__________ ____

MEDICATION LIST

Please list ALL medications (including prescription, skin patches, over–the-counter or vitamins) which you may be taking routinely and/or on an as needed basis.

	Drug Name (include vitamins)	**Frequency** (times per day)	**Dosage** (Mg)	**Route** (circle one)
1)				Oral/ Injection
2)				Oral/ Injection
3)				Oral/ Injection
4)				Oral/ Injection
5)				Oral/ Injection
6)				Oral/ Injection
7)				Oral/ Injection
8)				Oral/ Injection
9)				Oral/ Injection
10)				Oral/ Injection

Patient Signature____ Date:_____/______/______