Confidential
Medical History Form

ProActFit, LLC
Physical Therapy & Wellness
Strength and Conditioning

Legal Name: ______________________________ Date: ______________

Seeking Physical Therapy for: ______________________________

1. Statement of Present Health: ____ Excellent ____Good ____Fair/Poor - Please explain below

____

2. Do you or currently experience or in the past have you experienced any one of the following? Please circle below.

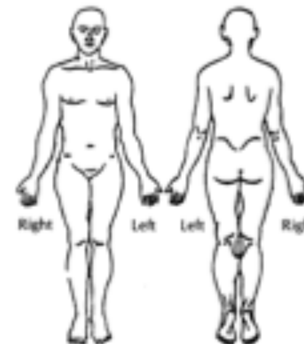
3. Do you have difficulty exercising or unable to function due to pain? Yes No

low back pain	elbow/wrist/hand pain	low blood pressure	difficulty breathing	uncontrollable sweating	tingling
mid back pain	plantar fasciitis	stroke	dizziness/fainting	poor vision	numbness
neck pain	foot pain	joint replacement	chest pain	headaches	memory loss
knee pain	ankle pain	chronic fatigue	diabetes	heart trouble	muscle cramp
shoulder pain	muscle or joint aches / pains	shortness of breath	difficulty breathing	high blood pressure	lung or respiratory issues
hip pain	head injury	neurological	muscle cramps	history of falls	tight muscles
asthma	nausea	pregnant	stress	high cholesterol	head injury
nerve pain	vertigo	fibromyalgia	cancer	migraines	arthritis
OTHER:					

If yes, where:

____

4. Area(s) of Pain ______________________________



Please RATE your pain area(s):

ZERO (0) = no pain or limitations
FIVE (5) = middle of the scale
TEN (10) = worst pain imaginable (call 911)

Highest and Lowest Number (circle below)

0 1 2 3 4 5 6 7 8 9 10

What makes the pain lessen, or feel better? ______________________________

____

What makes the pain worse? ______________________________

____

5. Have you had any recent surgeries or hospitalizations? Yes No
If yes, please explain (or attach a sheet) Date(s): ______________________________

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6. Please provide a list of medications you are currently taking (or attach a sheet).

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Physician or Specialist follow up date: ____

*Emergency Contact: ____
Name | Relationship | Emergency Contact Phone

Secondary Emergency Contact: ____
Name | Relationship | Emergency Contact Phone

I attest that the above information is true and correct to the best of my knowledge. I give ProActFit, LLC's owner's and contractors/ subcontractors permission to contact the above person(s) for the interest of my health or **in case of emergency.**

______________________ / ______________________ / ______________________
Patient Name **PRINT** (or legal guardian) | Patient Signature | Date / Time

______________________ / ______________________ / ______________________
Clinician Print Name | Clinician Signature | Date / Time