



# Altitude

PHYSICAL THERAPY & SPORTS MEDICINE

DIABETES	YES ___ NO ___	ALLERGIES	YES ___ NO ___
HIGH BLOOD PRESSURE	YES ___ NO ___	DERMATITIS	YES ___ NO ___
HEART DISEASE	YES ___ NO ___	PREV. SURGERY	YES ___ NO ___
HEART ATTACK	YES ___ NO ___	HERNIA	YES ___ NO ___
PACEMAKER	YES ___ NO ___	SEIZURES	YES ___ NO ___
HEADACHES	YES ___ NO ___	METAL OR OTHER	YES ___ NO ___
KIDNEY PROBLEMS	YES ___ NO ___	IMPLANTS	
NERVOUS DISORDERS	YES ___ NO ___	NUMBNESS	YES ___ NO ___
BLOOD DISORDERS	YES ___ NO ___	CANCER	YES ___ NO ___
FIBROMYALGIA	YES ___ NO ___	OSTEOPOROSIS	YES ___ NO ___
RHEUMATOID	YES ___ NO ___	OSTEOPENIA	YES ___ NO ___
ARTHRITIS		DO YOU SMOKE?:	YES ___ NO ___
ARTHRITIS	YES ___ NO ___		
FEMALE PATIENTS ONLY:		ARE YOU PREGNANT?	YES ___ NO ___

ARE YOU PRESENTLY TAKING MEDICATIONS? IF SO, LIST THE MEDICATION AND THE FREQUENCY AT WHICH IT IS TAKEN: \_\_\_\_\_

PLEASE LIST ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW ABOUT YOUR MEDICAL HISTORY SO THAT WE MAY HAVE A MORE COMPLETE UNDERSTANDING OF YOUR PROBLEM:

WHAT OTHER PRIMARY HEALTH CARE PROFESSIONALS HAVE YOU SEEN IN THE LAST YEAR? (FAMILY PRACTITIONERS, INTERNISTS, OB-GYN, CHIROPRACTORS, ETC. . .)

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: \_\_\_\_\_ PATIENT: \_\_\_\_\_