Brunswick Physical Therapy, PLLC.
Medical History

Patient Name:			Date:
Prescription Medications			
Name of Medication	**Dosage Ex (mg, cc)**	**Frequency Ex (2 x Daily)**	**More Info if needed**
Surgery Dates (Past & Present)	**Body Part**	**Allergies**	**Reaction**

Place an "X" if you have experienced or been told that you have any of the following:					
Asthma		Kidney Disease		Fainting	
Emphysema		Hepatitis/Jaundice		Migraine/Headaches	
Chest Pain		Bowel/Bladder Problems		Osteoporosis	
Heart Disease		Blood Disorder		Cancer	
Stroke		Pregnancy		Visual Loss	
Dizziness		Shortness of Breath		Hearing Loss	
Epilepsy/Seizures		High Blood Pressure		Chemical Dependency	
Arthritis		Blood Clot		Depression	
Diabetes		Head Injury/Concussion		Anxiety	
Fibromyalgia		Any Neurological Diseases		Thyroid Problems	
AIDS/HIV		Other:			

Place an "X" for all that apply to what you are being seen for today only:					
X-Ray		Ct Scan		MRI	
Ultrasound		Bone Scan		Blood Test	
EMG		NCV		Other:	

Please list any other information you feel we should know