COASTAL
PHYSICAL THERAPY

Confidential Medical Information

Date of Onset / Injury / Accident _____ ☐ Estimated

Please state current problem(s): _____

_____

Are you currently being treated by:

Another Therapist	____ Yes	____ No	Or within the last 12 months	____ Yes	____ No
Chiropractor / Osteopath	____ Yes	____ No	Or within the last 12 months	____ Yes	____ No
Home Health Agency	____ Yes	____ No	Or within the last 12 months	____ Yes	____ No

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check if you currently have or previously had any of the following:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Heart Problems

specify: _____

_____

_____

- ☐ High Blood Pressure
- ☐ Gout
- ☐ Seizures
- ☐ Stroke
- ☐ Ulcers
- ☐ Other Illnesses

specify: _____

_____

_____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____