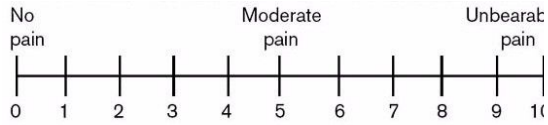
MANA PERFORMANCE THERAPY
FOR SPORT & LIFE
PHYSICAL THERAPY • STRENGTH TRAINING • SPORT PERFORMANCE

Client Medical History Form

What is your primary issue that brings you in?

_____

Date of Injury/Onset:_____ Date of Surgery (If Applicable):_____



When is pain at its worst?_____

When is pain at its best? _____

Do you have or have you had: (circle one)

High Blood Pressure?
Yes No

Diabetes?
Yes No

Heart Problems? (Murmurs, Abnormal Rate)
Yes No

Headaches?
Yes No

Chest Pain?
Yes No

Fainting? Dizziness? Seizures?
Yes No

Asthma, Allergies, Sinus Issues?
Yes No

Skin Conditons (Eczema, Rashes, Shingles)
Yes No

Recent Unintentional Weight Loss?
Yes No

Smoking History?
Yes No

Kidney or Bladder Problems?
Yes No

Allergies to Food/Medication?
Yes No Which?

Current Medications:_____

Past Surgical History (type and year performed):_____

Client/Guardian Name (Print)_____
Date:_____

All of the above information is true and complete

Client Name / Guardian Signature: _____
Date:_____