# MEDICAL HISTORY

**Patient Name:** **PTOS #:**

| Have you ever had? | YES | NO | Have you ever had? | YES | NO |
|---|---|---|---|---|---|
| Diabetes | | | Heart Attack | | |
| If diabetic, insulin dependent? | | | Heart Catheterization | | |
| Epilepsy | | | Pacemaker | | |
| Stroke | | | Angina | | |
| Cancer | | | High Blood Pressure | | |
| Orthopaedic problems | | | Lung Disease | | |

Please explain any **"yes"** answers or list any other pertinent medical history information._____

_____

# PRESENT SYMPTOMS REVIEW

| Have you recently had? | YES | NO | Have you recently had? | YES | NO |
|---|---|---|---|---|---|
| Chest pain with exertion | | | Leg cramping | | |
| Shortness of breath | | | Swollen, stiff or painful joints | | |
| Fainting with exercise | | | Muscle weakness | | |
| Heart palpitations | | | Numbness or tingling | | |
| Headaches | | | Other: | | |

**Condition for which you were referred for treatment:**_____

_____

**Have you had previous treatment for this problem?** ❑Yes ❑No

**If yes, please explain:**_____

_____

**Please list all current medications**:_____

_____

**Do you understand your diagnosis?** ❑Yes ❑No

**If no, would you like your therapist to explain further?** ❑Yes ❑No

Therapist Comments:_____

**Do you understand what the prescribed treatment will do for you?** ❑Yes ❑No

**If no, would you like your therapist to explain further?** ❑Yes ❑No

Therapist Comments:_____

I certify that the information listed above is current and accurate.

Patient *(or responsible party)* Signature_____ Date_____

Therapist Signature_____ Date_____

************Do Not Write Below This Line Unless Instructed By a Member of the Concorde Therapy Group Staff ************

If you have been seen at Concorde Therapy Group within the last year, please review the information listed above, and correct and initial any incorrect information. Please check either (1) or (2) below then sign and date.

(1)_____I have reviewed the **Medical History** and **Present Symptoms Review** listed above and certify that the information remains current and accurate. I understand my diagnosis and the treatment I will receive.

(2)_____I have reviewed the **Medical History** and **Present Symptoms Review** listed above. I have changed and initialed any information that has changed. I understand my diagnosis and the treatment I will receive.

Patient *(or responsible party)* Signature_____ Date_____

I certify that I have reviewed the **Medical History** and **Present Symptoms Review** listed above.

Therapist Signature_____ Date_____