CONFLUENT
THERAPY SOLUTIONS

MEDICAL HISTORY

Name: ____ DOB: __________________

Surgery: ____ DATE: __________________

Physician: ____

What is your goal in working with **Confluent Therapy Solutions**? ______________________________________

____.

Please check all that apply:

				Medications (Dose & Frequency):
__	Angina	__	Low Blood Pressure	
__	Cancer __________________	__	Low Blood Sugar	_________________________
__	Chest Pain	__	Lung Disease	_________________________
__	Coronary Artery Disease	__	Lymphedema	_________________________
__	Diabetes I / II	__	Osteoarthritis (arthritis)	_________________________
__	Fainting Spells	__	Osteopenia	_________________________
__	Heart Attacks	__	Osteoporosis	_________________________
__	Heart Disease	__	Stomach Problems	_________________________
__	Heart Pacemaker	__	Wounds	_________________________
__	High Blood Pressure	__	Other _______________	_________________________
__	High Cholesterol	__	Other _______________	_________________________
__	Leukemia	__	Other _______________	_________________________

Previous PT service ***for this injury*** (inpatient, homecare/VNA, outpatient):________________________________

Other Surgeries: ____

Comments / Other:

To the best of my knowledge, questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform my therapist of any changes in medical status.

Signature: ____ Date: ____________________