

GOUVERNEUR PHYSICAL THERAPY, PLLC

PATIENT MEDICAL HISTORY AND TREATMENT CONSENT

Name: _____

Occupation _____ Are you currently working? _____

Describe your job: _____

Describe your injury or symptoms: _____

How did your injury occur? _____

What are your goals/expectation of your therapy treatment? _____

Have you ever received Physical Therapy for this condition/injury? _____

Are you presently being treated by a chiropractor? _____

If yes, for what condition? _____

Have you had: X-rays/MRI/CT Scan (circle) _____

Have you had any of the following? (Please check)

_____ Diabetes (IDDM or NIDDM) _____ Migraine Headaches _____ Heart Murmur (please explain) _____

_____ Rheumatic Fever _____ Varicose Veins _____ Lung Disease _____

_____ Cancer _____ Circulatory problems _____ Epilepsy/Seizures _____

_____ Broken Bone(s)/Fracture _____ Heart Disease _____ Arthritis _____

_____ Kidney Disease _____ Hypertension _____ Allergies _____

_____ Metal Implants _____ Osteoporosis _____ Current Infection _____

_____ Neurological Condition (numbness, weakness, tremors, seizures) _____

Other _____

List any medications you are presently taking: _____

List any surgeries you have had: _____

Do you smoke? _____ Have a pacemaker? _____ Exercise regularly? _____ Chest discomfort? _____

Females: Is there a chance you may be pregnant at this time? _____

I authorize Gouverneur Physical Therapy, PLLC, to render physical therapy care pursuant to a referral from a licensed physician, dentist, podiatrist, physician's assistant or nurse practitioner in accordance with Federal and NY State Law. I understand that I have the right to consent to; or refuse to consent to; any proposed therapy procedure after receiving information about the benefits and possible associated risks.

Patient Signature/Legal Guardian

Therapist Signature

Date