

Past Medical History Form

Do you currently have or have you ever had any of the following:

	Yes	No		Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/ Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Attack	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any surgical implants?	<input type="checkbox"/>	<input type="checkbox"/>

Please list the condition that you have been referred for: _____

Do you have any current or past health or medical problems that are not listed above?

Please list all surgeries and the approximate date of the operation: _____

Please list all medications that you are currently taking or provide a list: _____

Financial Policy

Payment is due at time of service. We accept cash, check, VISA, Mastercard, Discover, & American Express. We may accept assignment of insurance benefits after you insurance has been verified. Please select the type of health care coverage you have:

Attorney Auto Insurance Health Insurance Medicare Medicaid Self Pay Worker's Comp

Authorization

I authorize release of information/records to my physicians, lawyers, employers, and/or insurance companies. I authorize my insurance benefits to be paid directly to KETHLEY Physical Therapy &/or Jeremy Kethley, MPT.

Signature: _____

Date: _____