MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: ______________________________

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

	YES	NO	COMMENT		YES	NO	COMMENT
CANCER				OSTEOPOROSIS			
DIABETES				PACEMAKER			
HEART PROBLEMS				SKIN PROBLEMS			
HIGH BLOOD PRESSURE				INFECTIOUS DISEASE			
ASTHMA				SEIZURES			
ARTHRITIS				KIDNEY DISEASE			
STROKE				OTHER			

CURRENT MEDICATIONS

DRUG	DOSAGE/FREQUENCY	DRUG	DOSAGE/FREQUENCY

ARE YOU ALLERGIC TO ANY MEDICATIONS____

HAVE YOU EVER RECEIVED PHYSICAL REHABILITATION FOR THE PRESENT CONDITION? ______________________________

FALL HISTORY:

Injury as a result of a fall in the past year? ☐ YES ☐ NO Date of Fall: ______________________________

Two or more falls in the last year? ☐ YES ☐ NO Dates of Falls: ______________________________

SURGICAL HISTORY:

Body Region:____________________ Surgery Type:______________________________ Date of Surgery: _____________

Body Region:____________________ Surgery Type:______________________________ Date of Surgery: _____________

Body Region:____________________ Surgery Type:______________________________ Date of Surgery: _____________

PLEASE READ CAREFULLY, AND THEN SIGN:

I, ____________________________, authorize Iberia Sports & Rehabilitation, LLC to provide Physical Therapy treatment as needed. I also authorize the release of all medical records to my insurance company, attorney, referring physician, rehabilitation nurse or worker's compensation insurance. I herby authorize payments for services rendered to be made directly to Iberia Sports & Rehabilitation, LLC. I do hereby acknowledge my debt with Iberia Sports & Rehabilitation, LLC and that I am ultimately responsible for that debt. The above information is correct to the best of my knowledge and I understand that interest may be charged on any overdue accounts.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES, DESCRIBING THE PRIVACY PRACTICES AND SAFEGUARDS AS WELL AS MY RIGHTS WITH RESPECT TO MY PROTCTED HEALTH INFORMATION MAINTAINED AND USED BY IBERIA SPORTS & REHABILITATION, LLC.

____ ________________________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**