State of Franklin HEALTHCARE ASSOCIATES
Your Health, Our Focus

PHYSICAL THERAPY

Date: _____

Name: _____

Address: _____

Telephone Number: _____

Please list any surgeries you have had starting with the most recent:

_____

_____

_____

Do you have any of the following medical problems?

Pacemaker	( )	Diabetes	( )	Kidney Problems	( )	Other	( )
Lung Problems	( )	Hepatitis	( )	Seizures	( )		
Swelling	( )	High Blood Pressure	( )	Heart Disease	( )		
Strokes	( )	HIV positive	( )	Tuberculosis	( )		
Dizziness	( )	Arthritis	( )	Thyroid problems	( )		

Do you have any allergies? Please explain

_____

Are you currently pregnant?

_____

Please list any medications you are taking:

_____

_____

_____

_____

_____