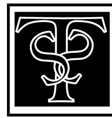
Specialized Therapy Services



2711 N. 92nd St. Milwaukee, WI 53222
Phone: 414-778-1341
Fax: 414-778-1342

Patient's Medical History:

Today's Date: ______________________

Patient name: ____ Sex: _____Date of birth: _____________

Height / weight: ______________________________

Occupation: ________________________________

Physician: __________________________________ Date of last Physical Examination: _____________

Physician's Clinic name and address: ____
____

Phone: ___________________________________ Fax: _________________________________

Check those that Apply:

______Recent illness, hospitalizations or surgical procedures
______Heart Attack, coronary bypass, cardiac surgery
______Abnormal resting or stress ECG
______Uneven, irregular, or skipped heart beats (including a racing or fluttering heart)
______High Cholesterol
______High Blood Pressure
______Diabetes
______Blood Clots
______Stroke
______Pulmonary Disease (asthma, emphysema, bronchitis, other breathing problems)
______Cancer
______Pregnant - How many months along? ______________________
______Ulcers
______Orthopedic problems or injuries (arthritis or any other bone, joint, or muscle problems)
______Emotional / psychological disorders (including stress, anxiety, or sleep disturbances)
______Physical Inactivity
______Smoking
______Drinking Alcohol (include frequency, i.e. 1x daily, 3x weekly etc.) ____________
______Chemical Dependency
______Medications: ____
______Allergies: ____

Please List any other health problems: ____
____
____

Please indicate any current or past forms of exercise that you have participated in (including leisure activities):
____
____

Patient expected goals: ____
____
____