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Paul Barbu, P.T.

TRINITY
MANUAL & SPORTS PHYSICAL THERAPY

Medical History

Last Name: _____ First Name: _____ DOB: _____ M / F

Yes No Do you have any allergies? If yes please explain: _____

Yes No Have you had any serious illnesses, surgeries or been hospitalized in the last five years?

If yes please provide dates: _____

Yes No Are you taking any medication, including non-prescription medication?

If yes what medication(s)? Include dosage and Frequency: _____

_____

Yes No Do you have any disease or problem not listed below that you feel we should know about?

If yes please explain: _____

Do you have, or have you had any of the following diseases or problems:

☐ Diabetes	☐ Circulatory	☐ Osteoarthritis	☐ Alcoholism
☐ Nervousness	☐ Rheumatoid Arthritis	☐ Hearing	☐ Depression
☐ Fibromyalgia	☐ Anemia	☐ Stroke	☐ Pace Maker
☐ Osteoporosis	☐ Drug Abuse	☐ Renal Disease	☐ Cancer
☐ High Blood Pressure	☐ Heart Disease	☐ Respiratory	☐ Seizures
☐ Migraines	☐ Dizziness	☐ Visual Field Disturbances	

Patient Consent

I hereby indicate my wish to be a participant in the rehabilitation program offered by **Trinity Manual & Sports Physical Therapy**. I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists possibility that certain changes may occur during my treatment.

I have been informed of the procedures and methods of treatment that will be administered to me, and I fully understand what is required of me as a patient. I verify that my participation is fully voluntary, no coercion of any sort has been used to obtain my participation, and I may withdraw from treatment at any time.

I understand that the facility administrator maintains an open-door policy and encourages patients to participate for any reason.

Patient Signature: _____ Date: _____
Or Parent/Guardian