**Medical History Form**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Heart Problems | ___ | ___ | Breathing Problems | ___ | ___ |
| Diabetes | ___ | ___ | Pacemaker | ___ | ___ |
| Seizures | ___ | ___ | High Blood Pressure | ___ | ___ |
| Dentures | ___ | ___ | Headaches | ___ | ___ |
| Smoker/Tobacco | ___ | ___ | Other:________________________ | | |

List Current Medications:___________________________________________________________

List any surgical procedures that you have undergone:____________________________________

________________________________________________________________________________

________________________________________________________________________________

Physical Complaint:_______________________________________________________________

________________________________________________________________________________

Have you had physical therapy or other treatment for this diagnosis before?

________________________________________________________________________________

________________________________________________________________________________

What are your expectations of physical therapy?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What are some personal goals for physical therapy?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Accident Patients only:**

Auto:___________ Work Related:_________Other:_________

**AUTHORIZATION FOR TREATMENT**

I authorize Star Care, Inc. To evaluate my condition and to carry out the plan of care determined by the Physical Therapist in agreement with my physician.

_________________________________ _________________________________

Witness Patient

________________

Date