

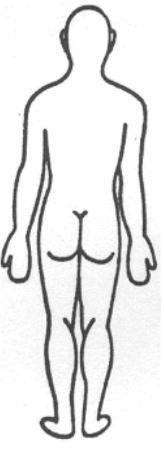
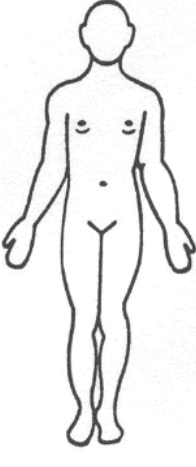
Edelman Spine & Orthopaedic Physical Therapy

Medical Information

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Dominant Hand: L R General Physical Condition/Health: Excellent Fair Good Poor

Please describe below and mark on the drawings the area[s] of your chief complaints:



FRONT VIEW

REAR VIEW

Please indicate (**by circling**) if you currently have or have a history of any of the following:

- | | |
|------------------------|---------------------------|
| Allergies | Hepatitis |
| Anemia | High Cholesterol |
| Arthritis | High / Low Blood Pressure |
| Asthma | HIV / AIDS |
| Autoimmune Disorder | Incontinence |
| Cancer | Kidney Problems |
| Cardiac Conditions | Metal Implants |
| Cardiac Pacemaker | MRSA |
| Chemical Dependency | Multiple Sclerosis |
| Circulation Problems | Muscular Disease |
| Currently Pregnant | Osteoporosis |
| Depression | Parkinson's Disease |
| Diabetes | Rheumatoid Arthritis |
| Dizzy Spells | Seizures |
| Emphysema / Bronchitis | Smoking |
| Fibromyalgia | Speech Problems |
| Fractures | Strokes |
| Gallbladder Problems | Thyroid Disease |
| Headaches | Tuberculosis |
| Hearing Impairment | Vision Problems |
| Anxiety | |

If you circled YES to any of the above, please explain: _____

Previous surgeries (include approximate date): _____