

**PHYSICAL THERAPY SPECIALISTS CLINIC, INC.**

**MEDICAL QUESTIONNAIRE**

Name \_\_\_\_\_ Date \_\_\_\_\_

List any known allergies \_\_\_\_\_

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Known side effects (swelling, skin rash, etc.) \_\_\_\_\_

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List any secondary **MEDICAL COMPLICATIONS** that you may have (heart condition murmur, diabetes, insulin shock, pacemaker, etc.) \_\_\_\_\_

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Family Doctor \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Friend/Relative **OUT OF HOUSEHOLD:** \_\_\_\_\_ Phone \_\_\_\_\_

I acknowledge the patient's above mentioned medical condition(s) and have documented them within the patient's medical record.

\_\_\_\_\_  
Evaluating Clinician

\_\_\_\_\_  
Date