PROGRESSIVE THERAPY

Client Name:_____

Medical History (Please check all that apply)

☐ Coronary heart disease ☐ Heart Condition ☐ Angina (chest pain) ☐ Infection Disease

☐ Blood Clot/Emboli ☐ Pacemaker ☐ Valve problems ☐ Heart attack

☐ High blood pressure ☐ Stroke/TIA ☐ Diabetes I or II ☐ Epilepsy/Seizures

☐ Stomach Ulcers ☐ Bowel or Bladder Problem ☐ Headaches ☐ Thyroid Condition

☐ Cancer – Type:_____

☐ Lung Disease (COPD, Asthma, Emphysema) – Type _____

☐ Arthritis: Rheumatoid/Osteoarthritis ☐ Osteoporosis/Osteopenia

Where:_____

Surgery in the last 12 months - Body part: _____ When _____

Have you had any testing for this condition? ☐ X-rays ☐ MRI ☐ EMG/Nerve Conduction Test ☐ CT Scan

Any chronic illness or condition – What type?_____

Allergies (Medications, Latex, Seasonal) _____

☐ Hernia (or any condition which can be aggravated with lifting)

☐ Current smoker ☐ Former smoker

☐ Pregnant/Possibly Pregnant

☐ Memory Loss / Alzheimer's / Dementia ☐ Circulation/Vascular Problems

Previous Broken Bones Location_____

☐ Balance Disorder ☐ Vertigo ☐ Depression

*Please list any medications that you are taking at this time:

_____

_____

_____

Currently Employed? ☐ Yes ☐ No If Yes, Job Title:_____

Thank you for choosing Progressive Therapy!

Patient's Signature _____ Date _____

Therapist Signature_____ Date _____