Integrated Physical Therapy, Inc.

FOR MEDICARE PATIENTS:

PLEASE CHECK YOUR PRESENT SYMPTOMS:

___Allergies
___Anemia
___Anxiety
___Arthritis
___Asthma
___Alzheimer's
___Cancer
___Cardiac Conditions
___Cardiac Pacemaker
___Chemical Dependency
___Circulation Problems
___Currently Pregnant
___Depression
___Diabetes
___Dizzy Spells
___Emphysema/Bronchitis
___Fractures
___Gall
___Hepatitis
___ High Blood Pressure
___Incontinence
___Kidney Problem
___Metal Implants
___Multiple Sclerosis
___Osteoporosis
___Parkinson's
___Rheumatoid Arthritis
___Seizures
___Speech Problems
___Strokes
___Thyroid Disease
___Tuberculosis
___ Vision Problems

Other :

LIST ALL PREVIOUS SURGERIES:

Area of Body:	Date:	Describe:

LIST ALL MEDICATIONS CURRENTLY TAKING:

Drug:	*Dosage:*	*Frequency:*	*Route:*	*Reason Taking:*

I authorize the release of any information to assist with any insurance payments. Please sign and date below to acknowledge that the above information is to the best of your ability true and correct.

Patient/Guardian Signature:_____ **Date:**_____