Steve Cuddy, MPT, PRC

Postural Restoration®/Manual Therapy/Custom Orthotics
1913 Pequeno Street
Austin, TX 78757
512.769.9081

Medical History

Name _____ Date _____

Please check "yes" or "no" to the following health problems.

Yes	No		Yes	No		Yes	No	
___	___	Cancer	___	___	Pulmonary/Breathing	___	___	HIV/AIDS
___	___	Diabetes	___	___	Liver disorder/disease	___	___	Tuberculosis
___	___	Heart disease	___	___	Kidney/bladder disease	___	___	Arthritis
___	___	Chest pain	___	___	Thyroid disorder	___	___	Rheumatism
___	___	High blood pressure	___	___	Intestinal disorder	___	___	Dizziness
___	___	Arrythmia or pacemaker	___	___	Seizure	___	___	Fainting
___	___	High cholesterol	___	___	Open sore/wound	___	___	Smoking
___	___	Anemia/blood condition	___	___	Hepatitis	___	___	Recent or current illness
___	___	Unexplained weight loss				___	___	Severe night pain
___	___	Bladder or bowel control problems				___	___	Unexplained weakness
___	___	Steroid or blood thinner use						
___	___	Allergies to latex						
___	___	Other _____						
___	___	Are you pregnant or is there any chance that you may be pregnant?						

Please explain why you are currently in need of physical therapy/what is your primary complaint:

_____

Please list any surgeries that you have had (with date):

_____

Please list any recent hospitalizations with (with date): _____

Current or recent medications: _____

Recent films (x-ray, MRI, CT scan) or other tests: _____

I have completed this questionnaire and have had any questions regarding its content answered fully. I understand that if information has been left out for confidentiality reasons, I may be putting myself and the therapist's safety at risk. I understand that if I choose not to disclose information in writing I may verbally communicate conditions to my therapist.

Signature _____ Date _____

Signature of guardian (if patient is under 18) _____