

**AOR Physical Therapy, Inc.**  
 2031 W. Alameda Ave. , Suite 300  
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 Voice (818) 558-6843 Fax (818) 558-1487

**PATIENT HISTORY FORM**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do you now have, or have ever had, any of the following (please circle one)?

Diabetes	Yes	No	Allergies	Yes	No
High Blood Pressure	Yes	No	Previous Surgery	Yes	No
Pacemaker	Yes	No	Seizures	Yes	No
Chronic Headaches	Yes	No	Metal implants	Yes	No
Liver / Kidney Conditions	Yes	No	Dizziness	Yes	No
Nervous Disorders	Yes	No	Cancer	Yes	No
Bone Disease	Yes	No	Osteoporosis	Yes	No
Bowel / Bladder Conditions	Yes	No	Anemia	Yes	No
Breathing Conditions	Yes	No	Depression	Yes	No
Circulatory Disease	Yes	No	Glaucoma	Yes	No
Heart Conditions	Yes	No	Corneal Implants	Yes	No
Stroke / CVA	Yes	No	Smoker	Yes	No
Thyroid Condition	Yes	No	Other illness	Yes	No
Hernia	Yes	No			

If **YES** to any of the above, please: explain, give dates, and appropriate details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently pregnant (please circle one)?      Yes      No      N/A

List any medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

Have you ever had physical therapy treatments for this current problem before (please circle one)?      Yes      No

If **YES**, indicate where, when, and was the treatment effective:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
 Patients Signature

\_\_\_\_\_  
 Date