GSPORTS
PHYSICAL THERAPY

Medical History

Please check box if any of the following pertain to you:

☐ Osteoarthritis
☐ Cardiovascular Disease
☐ Diabetes Mellitus Type 1
☐ Pace Maker
☐ Diabetes Mellitus Type 2
☐ Cancer: _____

☐ Allergies: _____

☐ Other Complicating Factors: _____

☐ Surgical History: _____

☐ Previous Physical Therapy: _____

☐ Diagnostic Testing (e.g., x-rays, MRI, etc.): _____

☐ Prescription Medications: _____

☐ Over the Counter Medications: _____

☐ Herbal/Vitamin/Mineral/Dietary Supplements: _____

☐ Other Medications: _____

How did you hear about us?

☐ Insurance Company
☐ The Bay Club
☐ Google
☐ Doctor:_____
☐ Equinox
☐ Yelp
☐ Other: _____
☐ 24-Hour Fitness
☐ Facebook
☐ Friend or Family Member: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

The signature below certifies the information above is true and correct.

_____
Patient or Guardian Signature

_____
Patient Name Printed

_____
Date

☐ I am a returning patient and I certify there are no changes to my medical history.

_____
Patient or Guardian Signature

_____
Patient Name Printed

_____
Date