FORD
PHYSICAL
THERAPY LLC

Systems Review

Patient Name: _____

Date: _____ **DOB:** _____

HEALTH INFORMATION: Do you suffer from any of the following?

- ❑ Fracture
- ❑ High Blood Pressure
- ❑ Tingling
- ❑ Dizziness
- ❑ Joint Swelling
- ❑ Numbness
- ❑ Metal Implants
- ❑ Heart Trouble
- ❑ Arthritis
- ❑ Diabetes
- ❑ Cancer
- ❑ Seizures
- ❑ Communicable Diseases
- ❑ Other

Allergies _____

Past Surgeries _____

Medications _____

NEXT SCHEDULED APPOINTMENT WITH REFERRING DOCTOR _____