ice Use Only:
Patient's Name:_____
DOB:_____

In Touch Physical Therapy

Your Pain Stops Here

Today's Date:_____

Past & Current Medical History

Please check all that apply

	Yes	No	Family
Allergies			
Alzheimer's			
Anxiety			
Asthma/COPD			
Cancer			
Depression			
Diabetes			
Chronic Pain			
Heart Disease			
High/Low (circle one) Blood Pressure			
High Cholesterol			
HIV/AIDS			
Immunosuppression			
Multiple Sclerosis			
Osteoarthritis			
Autoimmune			
Are you Pregnant?			
Other not previously listed:			

123 W Broadway St
P.O. Box 553
Owatonna, MN 55060

Phone- 507-451-7888
Fax- 507-451-3322
www.Intouchpt.com

In Touch Physical Therapy

Your Pain Stops Here

Patient Name:	Date of Birth:	Date:
Allergies:		

Name of prescription	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (By mouth, injection, ect.)

Over the Counter medication or nutritional supplement	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (By mouth, injection, ect.)

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