Performance Physical Therapy of
Naples, Inc.

(239) 643-2040 North Office
(239) 732-9094 East Office
(239) 593-3010 Immokalee Rd Office
www.pptofn.com

Medical History

Patient Name: _____ Date: _____

Surgical History (Check Box)		**Date of Surgery**		**Date of Surgery**
□ Knee Surgery	□ L □ R		□ Neck Surgery	
□ Shoulder Surgery	□ L □ R		□ Cancer Removal	
□ Total Hip Replacement	□ L □ R		□ Back Surgery	
□ Total Knee Replacement	□ L □ R		□ Other	
□ Heart Procedure (Bypass or Stent)				

Medical Condition (Check Box)	**Date of 1st Occurrence**		**Date of 1st Occurrence**
□ High Blood Pressure		□ Cancer (Type)	
□ High Cholesterol		□ Asthma	
□ Diabetes		□ Stroke	
□ Osteoarthritis		□ Pacemaker	
□ Osteoporosis		□ Other	
□ Cardiac Arrhythmia			

Medications

If you have a medication list please allow us to copy it at the front desk.

Current Medications	Reason

Treatment Related to Current Condition

Type of Treatment (Check all that apply)	Start Date	End Date	Improved
□ Home Health			□ Y □ N
□ Primary Physician			□ Y □ N
□ Orthopedic Surgeon			□ Y □ N
□ Physical Therapy			□ Y □ N
□ Chiropractor			□ Y □ N
□ Neurologist			□ Y □ N
□ Physiatrist			□ Y □ N