

# Steve Cuddy, MPT, PRC

Postural Restoration®/Manual Therapy/Custom Orthotics  
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Austin, TX 78703  
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## Medical History

Name \_\_\_\_\_

Date \_\_\_\_\_

Please check "yes" or "no" to the following health problems.

Yes	No		Yes	No		Yes	No		
___	___	Cancer	___	___	Pulmonary/Breathing	___	___	HIV/AIDS	
___	___	Diabetes	___	___	Liver disorder/disease	___	___	Tuberculosis	
___	___	Heart disease	___	___	Kidney/bladder disease	___	___	Arthritis	
___	___	Chest pain	___	___	Thyroid disorder	___	___	Rheumatism	
___	___	High blood pressure	___	___	Intestinal disorder	___	___	Dizziness	
___	___	Arrhythmia or pacemaker	___	___	Seizure	___	___	Fainting	
___	___	High cholesterol	___	___	Open sore/wound	___	___	Smoking	
___	___	Anemia/blood condition	___	___	Hepatitis	___	___	Recent or current illness	
___	___	Unexplained weight loss				___	___	Severe night pain	
___	___	Bladder or bowel control problems				___	___	Unexplained weakness	
___	___	Steroid or blood thinner use							
___	___	Allergies to latex							
___	___	Other _____							
___	___	Are you pregnant or is there any chance that you may be pregnant?							

Please explain why you are currently in need of physical therapy/what is your primary complaint:

\_\_\_\_\_  
Please list any surgeries that you have had (with date):

\_\_\_\_\_  
Please list any recent hospitalizations with (with date): \_\_\_\_\_

Current or recent medications: \_\_\_\_\_

Recent films (x-ray, MRI, CT scan) or other tests: \_\_\_\_\_

**I have completed this questionnaire and have had any questions regarding its content answered fully. I understand that if information has been left out for confidentiality reasons, I may be putting myself and the therapist's safety at risk. I understand that if I choose not to disclose information in writing I may verbally communicate conditions to my therapist.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of guardian (if patient is under 18) \_\_\_\_\_

