DEFY
THERAPY & WELLNESS
15807 Biscayne Blvd #113, N. Miami Beach, FL 33160 ,T. 786.955.6912, F. 786.955.6956
Email: info@defytherapyandwellness.com
defytherapyandwellness.com

Medical Health History

Patient Name: _____ DOB:_____

Height/Weight: _____ Referring Physician: _____

Please Mark an (X) if have had, or now have, the following conditions or treatments:

- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Stroke
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Asthma
- ☐ High Cholesterol
- ☐ Hernias
- ☐ Nervous Condition
- ☐ Bleeding Disorders
- ☐ Seizures or Epilepsy
- ☐ Open Heart Surgery
- ☐ High Blood Pressure
- ☐ Psychological Disorders

- ☐ Broken Bones _____
- ☐ Metal Implants _____
- ☐ Cancer _____
- ☐ Surgery _____
- ☐ Bone Fusions_____
- ☐ Other _____

Are you pregnant or planning a pregnancy? Yes No

Are you taking any Medication? Yes No

If yes, please list and dosages: _____

_____

_____

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Have you been admitted to the hospital in the last year? Yes No

If yes, why? _____

Hospitalized On: _____/_____/_____ Discharged On: _____/_____/_____

Have you had Physical or Occupational Therapy in the past? Yes No

If yes, Started On: _____/_____/_____ Discharged On:_____/_____/_____

Are you currently under the care of a Home Healthcare Nurse and/or Therapist? Yes No

(Nursing care at home: blood pressure checks, injections, wound care, insulin etc., physical or occupational therapy care at home, cleaning service at home, etc.)

If yes, Started On: _____/_____/_____ Discharged On:_____/_____/_____

I, _____ (print name) certify that I am not receiving Home Healthcare at this time and that if I begin to receive home Healthcare, I will notify Defy Therapy & Wellness. If I am recommended by any doctor to receive Home Healthcare, as specified above, before such service starts, I will be responsible for payment of the services rendered by Defy Therapy & Wellness.

_____ _____ _____
Patient's Signature Date Therapist's Signature