This section for children under 18 only:

Name of responsible party____________________Social Security#______________

Home Phone______________________Work Phone_________________________

I____________________Give permission to Coppola Physical Therapy to treat my child which would include any modalities which the doctor may prescribe.

MEDICAL INFORMATION (IF YES PLEASE ***CIRCLE***)

Past History	**Present Symptoms**
Asthma	Awaken short of breath
Cancer	Arthritis
Diabetes/High blood sugar	Back pain
Disease of arteries	Chest pains
Epilepsy/Seizures	Cough on exertion
Heart trouble	Heart palpitations
High blood pressure	Lightheadedness
Hypoglycemia	Loss of consciousness
Injuries to back	Shortness of breath
Injuries to knees or ankles	Swollen legs
Lung disease of arteries	Use more than one pillow for sleep
Rheumatic fever	Other_____________________
Rhythm abnormalities	
Stroke, heart attack	
Varicose veins	
Operations	
What type?____________	
Other__________________	

Family History

Have any of your blood relatives (parents, sisters, brothers) had/have: **(Circle)**

Cancer	Congenial heart disease
Heart attacks	Diabetes
High blood pressure	High Cholesterol
Heart operations	Other_______________________

I________________________give permission to Coppola Physical Therapy to release my records to my physician and insurance company.

Signature____________________________Date______________________

I__________________________give my consent to release any medical records to Coppola Physical Therapy necessary to aid in my treatment.

Signature____________________________Date______________________