Restore Occupational Therapy
693 Main Street
New Milford, PA 18834

Patient Medical History

Name: _____ Date: _____

DOB: _____ Are you seeing another therapist(circle): yes or no

Primary care MD: _____Referring MD: _____

Please briefly describe what brings you in to see the therapist today:

_____

_____

Please supply a list of current medications to us or list them below:

Medication	Dose	Reason

Please list past medical history:

_____

_____

_____

Please list any allergies:

_____

_____

_____