HEALTH HISTORY

To ensure that you receive a complete and thorough evaluation, please provide us with the important background information on this form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Name:_____ Leisure Activities:_____

Please check any of the following whose care you are under:
_____Medical Doctor (MD) _____Psychiatrist/Psychologist _____Occupation Therapy

ALLERGIES: List any medication(s) you are allergic to:_____ Are you latex sensitive? Yes No
List any other allergies we should know
about:_____

_____Osteopath _____Physical Therapist _____Other_____
_____Dentist _____Chiropractor _____Other_____

Date of last physical Examination:_____
If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):_____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer, if YES, what kind:_____
YES NO Heart Problems if YES, what kind: _____
YES NO Heart Disease, if YES, what kind:_____
YES NO Pacemaker
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Stomach Ulcers
YES NO Chemical Dependency (i.e., Alcoholism)
YES NO Thyroid Problems
YES NO Diabetes
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Artificial Joints
YES NO Other Arthritic Conditions
YES NO Emphysema
YES NO Epilepsy
YES NO Migraine Headaches
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Immune Suppressed (HIV/AIDS)
YES NO Kidney Disease, if YES, what kind: _____
YES NO Blood Clots
YES NO Osteoporosis
YES NO Other:_____

Do you exercise? YES NO

If YES, what type?
_____
_____
_____
_____
_____
_____

On average, how many times per week do you exercise? _____

On average, how long do you exercise?
_____
_____

Do you know your body Mass Index (BMI)?
_____

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date/ Surgery or Hospitalization

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please describe any significant injuries for which you have been treated (including fractures, dislocations and sprains) and the approximate date of injury:

Date/ Injury Date/ Injury

1. _____ 2._____

3. _____ 4. _____

Has anyone in your immediate family (parents, brother, sisters) ever been treated for any of the following?

YES	NO Stroke	Yes	NO Cancers	YES	NO Kidney Disease
YES	NO Heart Disease	YES	NO Diabetes	YES	NO Alcoholism (Chemical Dependency)
YES	NO High Blood Pressure	YES	NO Depression	YES	NO Inflammatory Arthritis(Rheumatoid, Ankylosing)

List Medications you are taking that were prescribed by your physician:

1._____ 2._____

3. _____ 4. _____

List any vitamins, supplements, etc you are presently taking:

1. _____ 2. _____

3. _____ 3. _____

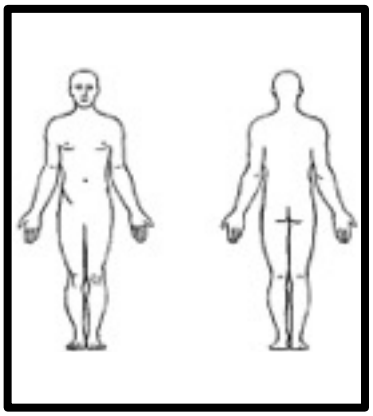
How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
Tobacco use: How many packs do you smoke per day? _____ for how many years?_____ If quit, when? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting per week? _____
My pain level is usually: 0 1 2 3 4 5 6 7 8 9 10 (Zero= No pain and 10= Extreme pain- going to the hospital)

Please rate your health at the current time: _____Excellent _____Very Good _____Fair _____Poor

Have you recently noticed?

YES	NO Weight loss/gain	YES	NO Arm/Leg Swelling
YES	NO Nausea/Vomiting	YES	NO Difficulty Swallowing
YES	NO Dizziness/ Lightheadedness/ fainting	YES	NO Heart Racing
YES	NO Weakness	YES	NO Heartburn/ Indigestion
YES	NO Fever/Chills/Sweats	YES	NO Blood in Urine
YES	NO Numbness or Tingling	YES	NO Pregnant/ think you might be
YES	NO Tremors	YES	NO Stress at home or work
YES	NO Seizures	YES	NO Problems Urinating
YES	NO Double vision	YES	NO Urinary Incontinence
YES	NO Loss of vision	YES	NO Post Menopausal
YES	NO Eye Redness	YES	NO Blood in Stools
YES	NO Skin Rash	YES	NO Constipation/ Diarrhea
YES	NO Problems Sleeping		
YES	NO Sexual Difficulties		
YES	NO Night Sweats		
YES	NO Hearing Problems		
YES	NO Joint/Muscle Swelling		
YES	NO Easy Bruising		
YES	NO Excessive Bleeding		
YES	NO Difficulty Breathing		
YES	NO Regular Cough		

Please draw pain areas:



Please list goals for physical therapy:

_____
_____
_____
_____
_____

_____
Patient Signature Date

_____
Therapist Signature Date