HEALTH HISTORY

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

Name: _____

Preferred Name and/or Pronouns if applicable: _____

Please place an X if you have ever been diagnosed as having any of the following conditions:

_____ Cancer; if so, what kind:_____
_____ Heart Problems or Disease; if so, what kind: _____
_____ Pacemaker
_____ High Blood Pressure
_____ Circulation Problems
_____ Asthma
_____ Stomach Ulcers
_____ Chemical Dependency (e.g. Alcoholism)
_____ Thyroid Problems
_____ Diabetes
_____ Multiple Sclerosis
_____ Rheumatoid Arthritis
_____ Artificial Joints; if so, what kind: _____
_____ Other Arthritic Conditions
_____ Emphysema
_____ Epilepsy
_____ Migraine Headaches
_____ Depression
_____ Hepatitis
_____ Tuberculosis
_____ Stroke
_____ Immune Suppressed (e.g. HIV/AIDS)
_____ Kidney Disease; if Yes, what kind: _____
_____ Blood Clots
_____ Osteoporosis
_____ Other conditions: _____

Height: _____feet _____ inches

Weight: _____ lbs

Please describe your weekly physical activity for exercise or recreation:

_____

_____

Do you have any of the following Allergies or Conditions we should consider?

_____ Latex allergy
_____ Adhesives/Bandages skin sensitivity
_____ Lotion allergies
_____ Light Sensitivity
_____ Difficulty Hearing
_____ Memory Issues
_____ Other: _____

During the past month have you been bothered by having little interest or pleasure in doing things?
Yes No

During the past month have you been feeling down, depressed or hopeless?
Yes No

Do you ever feel unsafe at home?
Yes No

Has anyone hit you or tried to injure you in any way?
Yes No

Tobacco use if applicable:
How many packs do you smoke per day? _____ For how many years?_____ If quit, when? _____

Describe Marijuana or CBD use if applicable: _____

Continued on the back

Relevant Surgery, Hospitalization, or Significant Injuries:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____

Relevant Medications, Vitamins, Supplements you are taking (and dosages if you know them):

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
5. _____ Dosage: _____
6. _____ Dosage: _____

Please mark an "X" along the line at the point that best represents your pain level from 0-10 (No pain – Worst pain)

Current level of pain: 0 ---------- 5 ---------- 10
Best in the past week: 0 ---------- 5 ---------- 10
Worst in the past week: 0 ---------- 5 ---------- 10

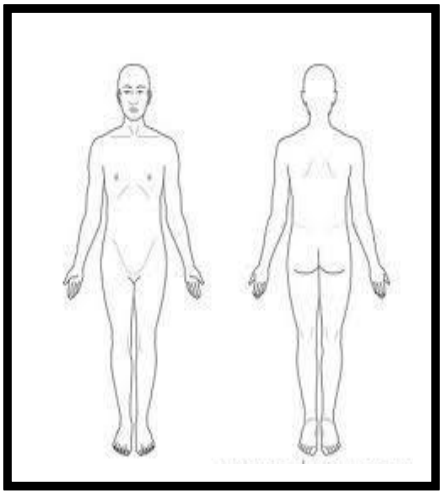
What make symptoms better? _____ **What makes symptoms worse? _____**

When did your pain and/or symptoms begin? _____

Please place an X if you have recently noticed:

_____ Weight loss or gain
_____ Nausea or Vomiting
_____ Frequent Cough
_____ Weakness
_____ Fever or Chills or Sweats
_____ Numbness or Tingling
_____ Fecal or Urinary Incontinence
_____ Seizures
_____ Double vision
_____ Loss of vision
_____ Pregnant or Think you might be
_____ Skin Rash
_____ Problems Sleeping
_____ Night Sweats
_____ Joint or Muscle Swelling
_____ Excessive Bleeding
_____ Dizziness, Lightheadedness, or Fainting
_____ Arm or Leg Swelling
_____ Difficulty Swallowing
_____ Heart Racing
_____ Heartburn or Indigestion
_____ Blood in Urine
_____ Eye Redness
_____ Stress at home or work
_____ Problems Urinating
_____ Tremors
_____ Menopausal Symptoms
_____ Blood in Stools
_____ Constipation or Diarrhea
_____ Sexual Difficulties or Pain
_____ Falls
_____ Easy Bruising
_____ Difficulty Breathing

Please circle affected areas:



Goal for Physical Therapy:

_____

_____

Patient Signature: _____

Date: _____