HEALTH HISTORY FORM

Name:______________________________ Age:________ Date of Birth:__________ Right / Left Handed (circle one)

Referring Physician:__________________________ Primary Care Physician:____________________________

Current Occupation:________________________________

Do you work: ☐ Full time ☐ Part time ☐ Unemployed ☐ Homemaker ☐ Student

What is your chief complaint:____

____

As a result of a: Car Accident_____ Work Accident_____ Other______________________________

Have you had physical therapy this year?________ How many visits?_________ Was treatment successful?__________

Aggravating Factors: ☐ Sitting ☐ Walking ☐ Coughing ☐ Exercise ☐ Rest ☐ Other_______________

Alleviating Factors: ☐ Sitting ☐ Walking ☐ Rest ☐ Other _______________________________

Allergies: ☐ Latex ☐ Medications ____

Medications (all prescription and non-prescription) This is **REQUIRED** by Medicare (Name, Dosage, Frequency, How Taken):

☐ Aspirin ☐ Ibuprofen ☐ Coumadin ☐ Prednisone ☐ List of Medications Attached

Other:____________________ ________________________ ______________________________

____________________ ________________________ ______________________________

Do you have a pacemaker/defibrillator? ____Yes ____No

Do you smoke? ____Yes ____No How long?_________ Chew tobacco?_______

Do you have insomnia? ____Yes ____No Hours of sleep?___________

Do you use illegal drugs? ____Yes ____No (circle) Marijuana Cocaine Methamphetamine Other_______

Do you drink alcohol? ____Yes ____No How often? ________ How much? _______

Unexplained weight loss: ____Yes ____No

Are you pregnant? ____Yes ____No

Surgeries:____

____

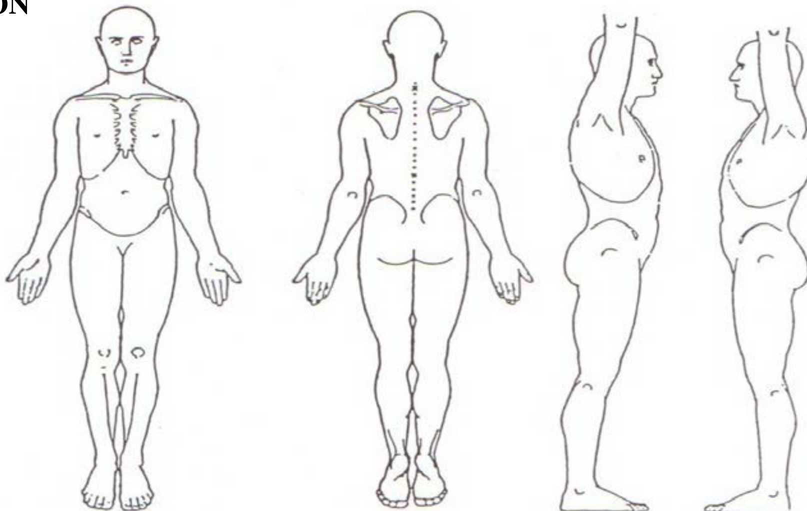
Imaging, X-rays, MRI, CT (specify by name, dates and results if known):_____________________________

____

Exercises when injury free (list recent activities, frequency, duration, as well as future goals):__________________

____

PAIN LOCATION



KEY

Use key to fill in body

o o o	Numb
+ + +	Tingling
d d d	Dull ache
x x x	Moderate pain
☐	Severe pain
↑	Shooting pain

INFECTION

- ☐ Lyme Disease
- ☐ HIV/AIDS
- ☐ Night sweats
- ☐ Kidney
- ☐ Hepatitis B or C
- ☐ Shingles

SPINE/BONES

- ☐ Fracture
- ☐ Dislocation
- ☐ Neck/back problems

LUNGS

- ☐ Asthma
- ☐ Tuberculosis
- ☐ Pain with deep breathing
- ☐ COPD/Emphysema
- ☐ Lung disease

BLOOD VESSELS

- ☐ Deep Vein Thrombosis
- ☐ Artery bypass surgery
- ☐ Calf pain with walking
- ☐ Enlargement of calf or thigh
- ☐ Cold legs

HEART

- ☐ Bypass surgery
- ☐ Heart attack
- ☐ High Blood Pressure
- ☐ Valve disorder
- ☐ Arrhythmia (fast/slow)
- ☐ Cardiac arrest
- ☐ Congestive heart failure
- ☐ Chest, arm, jaw pain
- ☐ Fainting
- ☐ Palpatations
- ☐ Other:___________________

GASTROINTESTINAL/KIDNEY

- ☐ Gall bladder stones
- ☐ Appendix surgery
- ☐ Nausea
- ☐ Infection
- ☐ Blood in stool
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Ulcer
- ☐ Change in stools
- ☐ Swallowing difficulties
- ☐ Kidney infection
- ☐ Kidney stone
- ☐ Pain with urination
- ☐ Loss of urine control
- ☐ Inability to urinate

RHEUMATOLOGIC

- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Scleroderma aching
- ☐ Ankylosing Spondylitis
- ☐ Psoriatic Arthritis

NEUROLOGIC

Left/right leg weakness:
- ☐ Pain ☐ Tingling
- ☐ Numbness

Left/right arm weakness:
- ☐ Pain ☐ Tingling
- ☐ Numbness

- ☐ Stroke
- ☐ Parkinsons Disease
- ☐ Dimentia/Alzheimers
- ☐ Multiple Sclerosis
- ☐ Seizure
- ☐ ALS
- ☐ Guillain-Barre Syndrome
- ☐ Disc Bulge

REPRODUCTIVE ORGANS

Men:
- ☐ Prostate infection
- ☐ Hernia
- ☐ Urethra infection

Women:
- ☐ Birth control pills
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Excessive vaginal bleeding
- ☐ Ectopic pregnancy
- ☐ Pelvic pain

Other: ____________________
____

HORMONAL

- ☐ Thyroid condition
- ☐ Osteoporosis
- ☐ Osteomalacia
- ☐ Diabetes (year onset_____)
- ☐ Diabetes complications:____

____

PSYCHIATRIC

- ☐ Anorexia/Bulemia
- ☐ Severe depression
- ☐ Panic attack
- ☐ Psychotic disorder
- ☐ Borderline disorder
- ☐ Suicide attempt
- ☐ Other:_________________________

____

CANCER/BLOOD

- ☐ List any cancer and dates:_________

____
____

- ☐ Anemia
- ☐ Bleeding disorder

____
Patient Signature

Date:______________________

____
Therapist Signature

Date:______________________