Patient Label

Name ____________________

Date of Birth ____________________

Physical Therapy Health History

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

Name: ____________________ Occupation: ____________________

Leisure Activities: ____________________

Allergies

List any medication(s) you are allergic to: ____________________ Are you latex sensitive? ☐ Yes ☐ No

List any other allergies we should know about: ____________________

Have you declared the Advanced Clinical Directive of Do Not Resuscitate: ☐ Yes ☐ No

Medical History

Are you under the care of:

☐ Medical physician (MD)	☐ Dentist	☐ Physical therapist	☐ Other
☐ Osteopath (DO)	☐ Chiropractor	☐ Psychiatrist/Psychologist	

If other please list: ____________________

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 with any of the following conditions:

☐ Asthma	☐ Depression	☐ Kidney disease*	☐ Stomach ulcers
☐ Blood clots	☐ Diabetes	☐ Multiple sclerosis	☐ Stroke
☐ Cancer*	☐ Heart problems*	☐ Osteoporosis	☐ Thyroid problems
☐ Chemical dependency	☐ Hepatitis	☐ Rheumatoid arthritis	☐ Tuberculosis
☐ Circulation problems	☐ High blood pressure	☐ Other arthritic condition	☐ Other*

*If you have answered yes to cancer, heart problems, kidney disease or other, please describe: ____________________

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

Have you ever been threatened, hurt, made to feel afraid or humiliated by your partner or someone close to you? ☐ Yes ☐ No

Medical History (continued)

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

____

Have you had any of the following injuries: ☐ fracture ☐ dislocation ☐ sprains ☐ other injury

If you answered yes to any of the above, please describe and include approximate date: ____________________

____

Medications

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

☐ Alcoholism ☐ Depression ☐ High blood pressure ☐ Kidney disease

☐ Cancer ☐ Diabetes ☐ Inflammatory arthritis ☐ Stroke

☐ Chemical dependency ☐ Heart disease

Which of the following medications have you taken in the last week:

☐ Aspirin ☐ Herbal remedies ☐ Stomach ulcer medication ☐ Tylenol

☐ Anti-inflammatory (Advil, Motrin, Ibuprofen) ☐ Vitamin/mineral supplements

☐ Other - NOT prescribed by physician

Please list any physician prescribed medication you are currently taking (INCLUDING pills, injections and /or skin patches):

____

Social History

How much caffeinated coffee or caffeine containing beverages do you drink per day? ____________________

Do you smoke? ☐ Yes ☐ No ☐ Quit - When? ____________

How many packs do you smoke per day? ____________ For how many years? ____________

How many days per week do you drink alcohol? ____________

If one drink = one beer or glass of wine, how much do you drink at an average sitting? ____________

Complaints

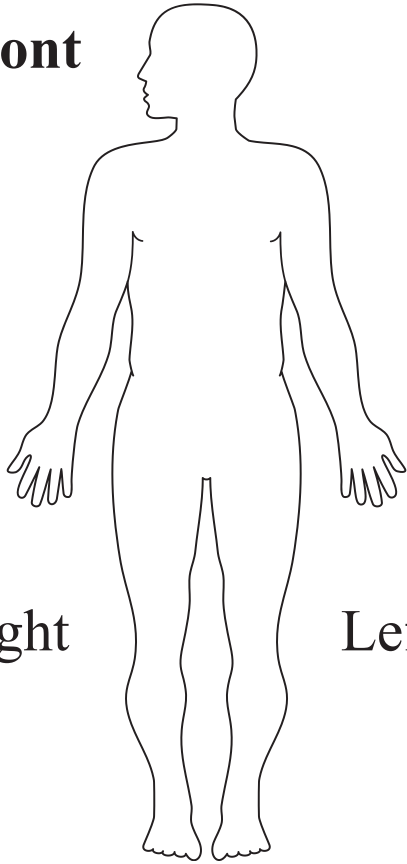
Please mark any of the following that are NEW, UNUSUAL or ATYPICAL for you;

☐ arm/leg swelling
☐ blood in stools
☐ blood in urine
☐ constipation/diarrhea
☐ difficulty breathing
☐ difficulty swallowing
☐ dizziness/lightheadedness
☐ double vision
☐ bruise easily
☐ excessive bleeding
☐ eye redness
☐ fatigue
☐ fever/chills/sweats
☐ hearing problems
☐ heart racing in your chest
☐ heartburn/indigestion
☐ joint/muscle swelling
☐ loss of vision
☐ nausea/vomiting
☐ night sweats
☐ numbness or tingling
☐ post menopause
☐ pregnant or think you might be
☐ problems sleeping
☐ problems urinating (difficulty starting, painful)
☐ regular cough
☐ sexual difficulties
☐ skin rash
☐ stress at home or work
☐ seizures
☐ tremors
☐ urinary incontinence
☐ weakness
☐ weight gain
☐ weight loss

Pain

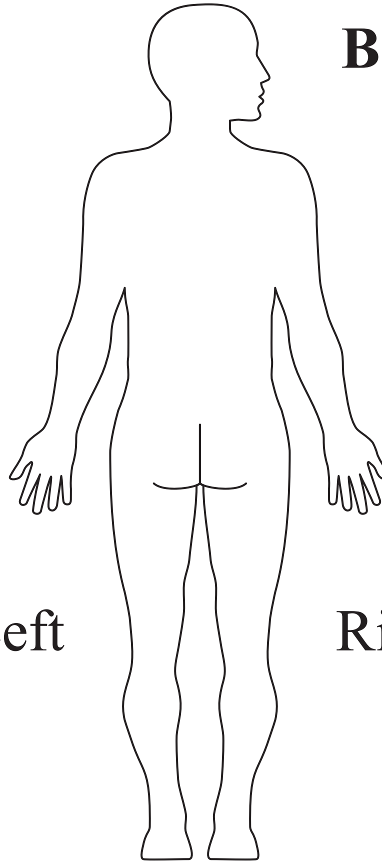
Where is your pain now? Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas to which your pain spreads (radiates). Include all affected areas.

Front



Right Left

Back



Left Right

- ⚡ Stabbing
- ● Tingling
- = Numbness
- + Pins and Needles
- ▲ Aching
- × Burning

I have reviewed and fully completed this form to the best of my ability. I understand this information will become part of my permanent medical record.

Patient signature: ______________________________ Date: _______ /_______ /_______

Therapist signature: ______________________________ Date: _______ /_______ /_______