

Patient Name: _____

PATIENT HEALTH HISTORY

Initial Evaluation Date _____ Height: _____ Weight: _____
 Do you have a prescription Yes No Referring practitioner: _____ Next MD visit: _____/_____/_____

Living arrangements:(In order to better plan your care)

- Patient owned/rented (house/apt/mobile home)
- Family member's residence
- Boarding home or rented room
- Board and care or assisted living
- Other: _____

With whom do you live? (In order to better plan your care)

- Alone
- With spouse/significant other
- Child/children
- Other relative(s)
- Group setting Other: _____

History of present condition:

Current complaints: _____

Body Part/Region: _____ When did your symptoms start(date): _____/_____/_____

If you are coming in due to an injury, how did you injure yourself?: _____

Special orders from physician: _____

Have you seen anyone else for this problem? Please list: _____

If you are coming in after surgery please explain: _____

Surgery Date: _____/_____/_____

Pain:

Please describe your pain: (i.e.: Burning/stabbing/ache) _____

Where is your pain located? _____

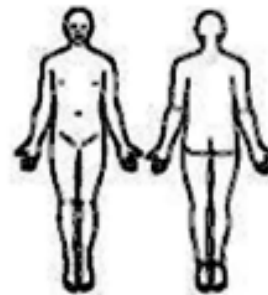
When is the pain at its worst? Morning Night With activity At rest

Please fill in the appropriate number for each of the below times:

Rating: **0** ----- **5** ----- **10:** Now? _____ At it's best? _____ At it's worst? _____
No Pain *Hospital*

Please draw your pain on the body to the right using the following symbols:

- //// Stabbing pain
- XXX Burning
- ooo Pins and needles
- ==== Numbness



Is the pain..?: Constant On and off

Are your symptoms getting...?: Better Worse Staying the same

What makes your symptoms worse? _____

What makes your symptoms better? _____

What activities do you have difficulty doing? _____

What previous activities do you want to resume? _____



Past Medical History:

If you have had any of the following conditions please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems/disease |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Heart burn |
| <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Unusual joint pain/swelling | <input type="checkbox"/> History of fractures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Emphysema/ bronchitis | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other arthritic conditions |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Anemia |

If none of the below apply please check here

- | | |
|---|--|
| <input type="checkbox"/> Angina/chest pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Increase in frequency or intensity of headache | <input type="checkbox"/> Impaired vision |
| <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Impaired hearing |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pregnant |

Have you recently noticed...? <input type="checkbox"/> Sudden unexplained weight loss/gain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Fever/chills/sweats <input type="checkbox"/> Numbness or tingling	Do you use a...? <input type="checkbox"/> Cane <input type="checkbox"/> Walker, Rolling Walker or Rollator? <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Motorized Wheelchair <input type="checkbox"/> Other: _____	General health status: <input type="checkbox"/> Smoker <input type="checkbox"/> Obese <input type="checkbox"/> Alcohol dependent <input type="checkbox"/> Drug dependent <input type="checkbox"/> Patients self report: _____
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List all previous surgeries and approximate dates:

Please check here if you have not had any previous surgeries

PROCEDURE	DATE

List diagnostic tests for this problem (include x-rays, MRI, EMG, ETC):

Please check here if you have not had any previous diagnostic testing

TEST	DATE	RESULT

List current medications, dosage, and purpose (including over the counter): Check each day a dose is taken

If you are not currently taking any medications please check here

MEDICATION	AMOUNT	TIME	SUN	MON	TUES	WED	THUR	FRI	SAT

I have verified the list of medications with the patient or authorized representative,

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Therapist signature: _____	Date: ____ / ____ / ____
Frequency: _____	PT Plan Visits: _____ ICD- 9 Code: _____