Health History Form

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

NAME: _____DATE: _____

GENERAL HEALTH STATUS: (Rate your overall health) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

WHAT ARE YOUR CHIEF COMPLAINT(S) / PROBLEM(S)? _____

WHAT PHYSICIAN REFERRED YOU FOR THIS INJURY / EPISODE? _____

WHEN DID YOUR SYMPTOMS BEGIN? (Specific date if possible) _____

HOW DID YOUR INJURY / PROBLEM OCCUR? _____

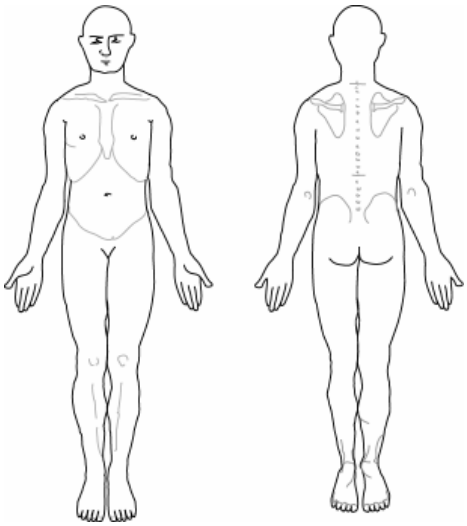
WHAT AGGRAVATES YOUR SYMPTOMS? (Check all that apply)

- ☐ SITTING
- ☐ GOING TO / RISING FROM SITTING
- ☐ SLEEPING
- ☐ COUGHING / SNEEZING
- ☐ TAKING A DEEP BREATH
- ☐ LOOKING UP OVERHEAD
- ☐ SWALLOWING
- ☐ STRESS
- ☐ SUSTAINED BENDING
- ☐ RECREATION / SPORTS
- ☐ STANDING
- ☐ OTHER _____
- ☐ SQUATTING
- ☐ LYING DOWN
- ☐ WALKING
- ☐ UP / DOWN STAIRS
- ☐ REACHING OVERHEAD
- ☐ REACHING IN FRONT OF BODY
- ☐ REACHING BEHIND BACK
- ☐ REACHING ACROSS BODY
- ☐ TALKING / CHEWING / YAWNING
- ☐ REPETITIVE ACTIVITIES
- ☐ HOUSHOLD ACTIVITIES

WHAT RELIEVES YOUR SYMPTOMS? (Check all that apply)

- ☐ SITTING
- ☐ HEAT
- ☐ COLD
- ☐ STRETCHING
- ☐ WEARING A SPLINT
- ☐ REST
- ☐ STANDING
- ☐ OTHER _____
- ☐ WEARING A SPLINT / ORTHOSIS
- ☐ WALKING
- ☐ EXERCISE
- ☐ LYING DOWN
- ☐ MASSAGE
- ☐ MEDICINE
- ☐ NOTHING

Please mark and localize your area of pain on the body chart below



DIAGNOSTIC TESTING FOR THIS INJURY / EPISODE: (Check all that apply)
☐ MRI ☐ CT Scan ☐ EMG ☐ Other: _____

SURGICAL HISTORY: (Please list any recent/relevant past surgeries to current problem)

_____DATE_____
_____DATE_____
_____DATE_____

☐ **NO SURGERIES TO DATE**

Circle Your Pain Scale

NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

CURRENT MEDICATIONS: (Or please give us a separate list)

_____
_____
_____

By signing this form I agree that the information given is true.

Signature_____ Date _____

PAST MEDICAL HISTORY

Have you ever had / been diagnosed with any of the following? (Check all that apply)

- ☐ DEPRESSION
- ☐ STROKE
- ☐ DIABETES
- ☐ ARTHRITIS
- ☐ HEAD INJURY
- ☐ ALLERGIES
- ☐ LIGHTHEADED
- ☐ HEART PROBLEMS
- ☐ KIDNEY PROBLEMS
- ☐ HISTORY OF FALLS
- ☐ INFECTIOUS DISEASES
- ☐ VISION PROBLEMS
- ☐ OSTEOPOROSIS
- ☐ PARKINSON'S DISEASE
- ☐ VASCULAR PROBLEMS
- ☐ NIGHT SWEATS
- ☐ BLOODY SPUTUM
- ☐ FEVER
- ☐ WEIGHT LOSS
- ☐ CANCER (TYPE) _____
- ☐ OTHER: _____
- ☐ HIGH BLOOD PRESSURE
- ☐ LUNG PROBLEMS
- ☐ THYROID PROBLEMS
- ☐ MENTAL / BEHAVIORAL
- ☐ EPILEPSY / SEIZURES
- ☐ MULTIPLE SCLEROSIS
- ☐ BROKEN BONE
- ☐ BLOOD DISORDERS
- ☐ HEART PROBLEMS
- ☐ CIRCULATION PROBLEMS
- ☐ INNER EAR DISORDERS
- ☐ VERTIGO
- ☐ RHEUMATOID ARTHRITIS
- ☐ PRODUCTIVE COUGH
- ☐ ANOREXIA

☐ DO YOU HAVE A PACEMAKER? YES NO
☐ ARE YOU CURRENTLY PREGNANT? YES NO