

Physical Therapy First, LLC

Health History (Please Print)

Patient Name (Last, First, MI)	Age:	Height:	Weight:	Today's Date
Do you have a pacemaker? Yes No	Do you smoke? Yes No	Are you latex sensitive? Yes No		

ALLERGIES:

MEDICATIONS (include pills, injections and/or skin patches):

Have you ever taken steroid medications for any medical conditions? Yes No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Yes No

SURGERIES, INJURIES, AND HOSPITALIZATIONS:

Diagnostic Tests (for example: x-ray, MRI, CT Scan, Bone Scan, blood tests):

Treatment received so far for this injury, pain, or problem:

Occupation, including activities that comprise your work day:

Are you on a work restriction from your doctor? Yes No If yes, explain:

Leisure activities, including exercise:

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? Yes No

Have you RECENTLY experienced any of the following (check all that apply)?

- | | | |
|---|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Dizziness/lightheadedness | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Difficulty maintaining balance while walking | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Falls | <input type="checkbox"/> Changes in bowel or bladder function | <input type="checkbox"/> Headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Epilepsy / Seizures |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Other arthritic condition | <input type="checkbox"/> Eye problem/infection |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Bladder/urinary tract infection | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney problem/infection | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bone or joint infection | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Chemical dependency (i.e., alcoholism, recreational drugs) | | |

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Blood clots |

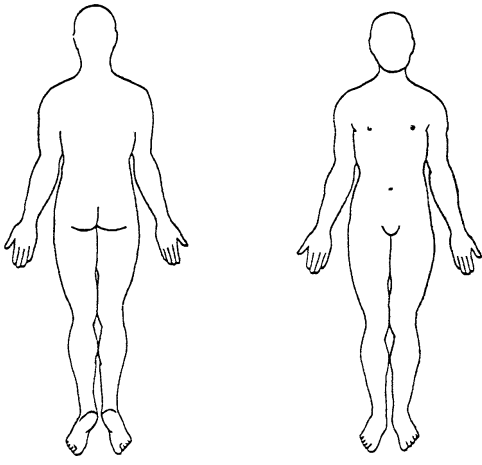
Approximately what date did your symptoms start (include surgery date if applicable)?

What do you think caused your symptoms, injury and/or pain?

My symptoms are currently: Getting Better Getting Worse Staying about the same

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓	Shooting/sharp pain
○	Dull/aching pain
	Numbness
=	Tingling



My symptoms currently: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: Can you identify positions or activities that make your symptoms worse?

- 1)
- 2)
- 3)

Symptom relieving Factors: Can you identify positions or activities that make your symptoms better?

- 1)
- 2)
- 3)

How are you currently able to sleep at night due to your symptoms?

- No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst? Morning Afternoon Evening Night After
exercise

When are your symptoms the best? Morning Afternoon Evening Night After
exercise

Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “emergency room pain” please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Have you ever had this injury before: Yes No When _____ Treatment rec'd _____