FOCUS PHYSICAL THERAPY: PATIENT HEALTH HISTORY FORM

NAME _____BODY PART _____DATE_____

When did your condition start: _____

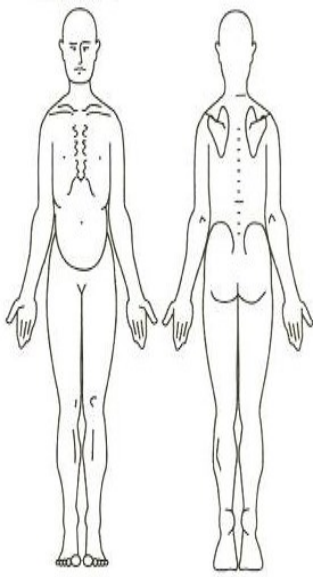
Did you have surgery? **YES NO** When? _____ What surgery was done? _____

Did you have any of the following tests? (Check) ☐ XRAY ☐ MRI ☐ CT Scan ☐ EMG ☐ OTHER_____

Who have you seen for your condition before today? (Check all that apply) ☐ MEDICAL DOCTOR ☐ MASSAGE THERAPIST ☐ CHIROPRACTOR ☐ PHYSICAL THERAPIST ☐ ACUPUNCTURIST ☐ OCCUPATIONAL THERAPIST ☐ SPEECH THERAPIST ☐ ATHLETIC TRAINER Name: _____ Next appointment?: _____

Are you currently taking any medications? **YES NO** Please list:_____
(use back of page if you need more space)

Do you have PAIN? If so DRAW on the BODY CHART where your pain is located >>>>>>>>>>>



Does pain radiate to arms or legs? **YES NO** Does the pain keep you up at night? **YES NO**

Rate your PAIN on a 0 to 10 scale: **0 1 2 3 4 5 6 7 8 9 10** (circle one)
(0=none, 10=severe)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities or household chores)? **0 1 2 3 4 5 6 7 8 9 10** (circle one)

Difficulty with:
☐ **LYING DOWN** ☐ **SITTING** ☐ **STANDING** ☐ **WALKING** ☐ **OTHER** _____

How often are your symptoms present?
☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:
☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?
☐ Getting Better ☐ Not Changing ☐ Getting Worse

In general would you say your overall health right now is:
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor **Height: _____ Weight: _____**

Activity Level: ☐ **LOW** ☐ **MEDIUM** ☐ **HIGH** Recent weight change: ☐ **Loss** or ☐ **Gain**? How much? _____

Are you Pregnant? **YES NO** Were you in a Motor Vehicle Accident? **YES NO** Is this a Work Injury? **YES NO**

Do you now or have had any of the following? (check what applies)

_____Heart Disease	_____ Diabetes	_____Allergies	_____ High Blood Pressure
_____Heart Attack	_____ Pacemaker	_____ Kidney Problems	_____ Headaches
_____Cancer	_____Seizures	_____Hernia (any)	_____Nervous Disorders
_____Stroke	_____Dizziness	_____Thyroid Problems	_____Asthma/Shortness of Breath
_____Previous Surgery	_____Metal Implants	_____Infectious Disease	_____Urinary Problems
_____Memory Problems	_____Pain at Night		

If yes to any of the above please give details and approximate dates. _____
_____

Any other conditions we should be aware of? _____

All statements above are true to the best of my knowledge_____
PATIENT SIGNATURE AND DATE