



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? _____

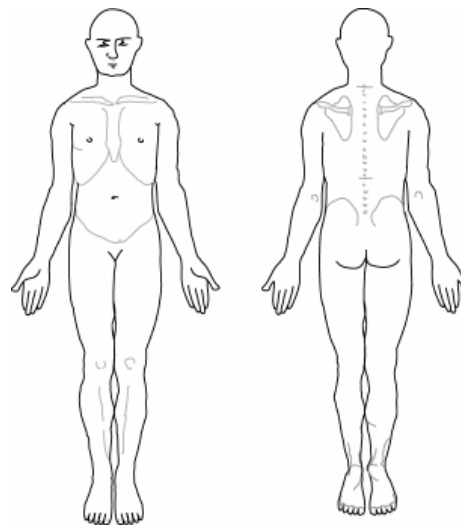
WHAT AGGRAVATES YOUR SYMPTOMS? (Check all that apply)

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

WHAT RELIEVES YOUR SYMPTOMS? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> SITTING | <input type="checkbox"/> WEARING A SPLINT / ORTHOSIS |
| <input type="checkbox"/> HEAT | <input type="checkbox"/> WALKING |
| <input type="checkbox"/> COLD | <input type="checkbox"/> EXERCISE |
| <input type="checkbox"/> STRETCHING | <input type="checkbox"/> LYING DOWN |
| <input type="checkbox"/> WEARING A SPLINT | <input type="checkbox"/> MASSAGE |
| <input type="checkbox"/> REST | <input type="checkbox"/> MEDICINE |
| <input type="checkbox"/> STANDING | <input type="checkbox"/> NOTHING |
| <input type="checkbox"/> OTHER _____ | |

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)

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

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