HEALTH HISTORY Height_____Weight_____ Right / Left Handed _____

Name_____DOB_____ Do you have a pacemaker ? Yes/ No

Are you taking any prescriptions or other medications? (Please list or include a photocopy):_____

_____

Have you had medical testing/lab work done recently (X-Rays/CT Scans,/MRI/etc)? If yes, please list _____

_____

_____

Have you had any operations/joint replacements? Yes / No (If yes, please list, with date):_____

_____

_____

Have you seen any other provider or physical therapist? (Please list) _____

_____

Present Condition:

Where is your pain?_____ (Left / Right) Circle Image

When or *how* do symptoms worsen? _____

Degree of pain *at rest*: 0--1--2--3--4--5--6--7--8--9--10

Degree of pain *with movement*: 0--1--2--3--4--5--6--7--8--9--10

Any known injury?: _____

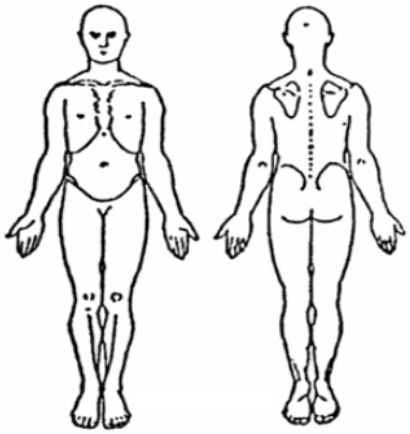
Is this a recurring injury? Yes / No When did it start? (Date) _____

Type of pain: (please circle)

Dull Sharp Constant Intermittent Localized Shooting Burning Tingling Numb

History of falls? Yes / No Frequency: _____

Do you use any special supports / braces? Yes / No (If yes, please list):



_____

Other history that my physical therapist should be aware of:

- ☐ Unexplained weight loss
- ☐ Fever
- ☐ Recent Significant Trauma
- ☐ Numb / weakness in arms
- ☐ Numb / weakness in legs
- ☐ Groin numbness
- ☐ Bladder / bowel changes
- ☐ Pain that worsens at night
- ☐ Fibromyalgia
- ☐ epilepsy
- ☐ high blood pressure
- ☐ diabetes
- ☐ heart problems
- ☐ stroke
- ☐ shortness of breath
- ☐ thyroid problems
- ☐ migraines
- ☐ kidney disease
- ☐ asthma
- ☐ polio
- ☐ liver disease
- ☐ emphysema
- ☐ depression
- ☐ anxiety
- ☐ multiple sclerosis
- ☐ arthritis
- ☐ cancer

Other? (please list or describe):

_____

_____

Signature_____**Date**_____