HEALTH HISTORY Height_____Weight_____

Name_____DOB_____

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

_____

Have you had any illness within the last 3 weeks? Yes / No_____

Do you have a pacemaker, organ transplant, joint replacement or any metal implants? Yes/ No (If yes, please list):

_____

Have you had medical testing done recently (X-Rays, CT Scans, or MRI's etc)? Yes / No (If yes, What?/Where?/When?)

_____

Have you had any lab work done recently? Yes / No (If yes, What?/Where?/When?/Results?)_____

_____

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

_____

_____

Have you ever received physical therapy before? Yes / No (If yes, Where?/When?/Why?)_____

_____

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

Present Condition:

Where is your pain?_____

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?_____

Type of pain: (please circle) Dull Sharp Constant Intermittent Localized Shooting Burning Tingling Numb

Work Environment:

Occupation:_____

Does your job involve: prolonged (please circle) Sitting Standing Walking ?

Use of office equipment (telephone, computer, cash register or similar)? Yes / No

Use of small or large equipment (drill press, forklift or similar)? Yes / No

Lifting, bending, twisting climbing, turning? Yes / No

Exposure to chemicals, pesticides, toxins, gases? Yes / No

Do you use any special supports (Back or neck cushion, back brace or corset, other brace for any body part)? Yes / No

(If yes, please list):_____

History of falls? Yes / No (If yes, please describe frequency):_____

Other history that my physical therapist should be aware of: (Fibromyalgia, epilepsy, high blood pressure, diabetes, heart problems, stroke, shortness of breath, Guillian-Barre, Hemophilia, thyroid problems, migraines, kidney disease, asthma, polio, liver disease, emphysema, depression, multiple sclerosis, arthritis, cancer, TB? **(please circle)**

Other? (please list or describe):_____

Signature_____**Date**_____