

PHYSICAL THERAPY ASSOCIATES – PATIENT HEALTH INFORMATION

To ensure that you receive a complete and thorough evaluation, please provide us with important background information. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Name: _____ Occupation: _____

Family doctor: _____ Leisure activities: _____

Why are we seeing you today: _____

What goals do you expect to meet with physical therapy: _____

List any medication(s) to which you are allergic: _____

Are you latex sensitive? Yes No

List any other allergies: _____

Do you have an "Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check if you are **currently** seeing any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Medical doctor (MD) | <input type="checkbox"/> Psychiatrist/Psychologist | <input type="checkbox"/> Osteopathic doctor (DO) |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Dentist | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Other _____ | | |

If you have seen any of the above during the past **three months**, please describe reason (illness, medical condition, routine physical, etc.)

Please check if you have **ever** been diagnosed as having any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer, If yes, what kind: _____ | | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/Bronchitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other Arthritic Conditions | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency (i.e. alcohol, etc.) | | |
| <input type="checkbox"/> Other _____ | | |

Do you feel unsafe at home or has anyone injured or tried to injure you? Yes No

Are you currently pregnant or think you might be pregnant? Yes No

Please list **surgeries/conditions** for which you have been hospitalized **that relate to your current problem.**

Date	Reason	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list **significant injuries** for which you have been treated. (Include fractures, dislocations, sprains, etc.)

Date	Injury
_____	_____
_____	_____
_____	_____

Please list any **prescription medications** you are currently taking (include pills, injections, and/or skin patches):

_____	_____
_____	_____
_____	_____

Please check any of the following over-the-counter medications you have taken **within the past month**?

- | | | |
|---|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Antacid |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Decongestants | <input type="checkbox"/> Antihistamines |
| <input type="checkbox"/> Advil/Motrin/Ibuprofen | <input type="checkbox"/> Vitamins/mineral supplements | |
| <input type="checkbox"/> Other _____ | | |

Please check if you have **recently noticed** any of the following:

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Malaise (mental uneasiness) | | |

MEDICAL HISTORY QUESTIONS FOR SELF-REFERRED PATIENTS ONLY

(If referred to our clinic by a health professional you do not need to complete the following questions)

Please check if anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Cancer (if yes, what kind) _____ | | |
| <input type="checkbox"/> Chemical Dependency (i.e. alcohol, drugs, etc.) | | |

How many **caffeinated coffee** or other **caffeinated beverages** do you drink per day? _____

Tobacco Use (circle one): Current Former User Never

How many **days per week** do you drink alcohol? _____

If one drink equals a beer, glass of wine, shot or mixed drink, how many drinks do you **consume at an average sitting**? _____

Therapist signature

Date