PATIENT HISTORY

Name_________________________________ Date ________________ Height____Weight____
Date of Injury:___________________________Date of Surgery:________________________________

CURRENT COMPLAINTS

1.___________________________ Problem begin date: __________ Symptoms are getting: Better / Worse

2. ___________________________ Problem begin date: __________ Symptoms are getting: Better / Worse

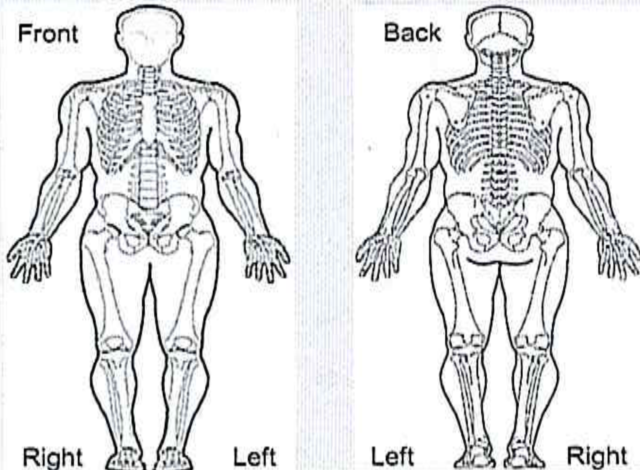
PRIOR TREATMENT

Have you been treated for above complaints? Y / N
If so, what type of service? ____
When? ____
Results of this service? ____

MEDICAL/ SURGICAL HISTORY

Please list any operations and/or injuries that you have ever had and the date:
1._________________________________ 2._____________________________________
3._________________________________ 4._____________________________________
Have you had any laboratory work done recently? If yes, what, when, and results?
_________________________________ _____________________________________

Have you ever been treated with chemotherapy, radiation therapy, biotherapy, or brachytherapy? Y / N



List activities or postures that make your symptoms worse:
1.___________________________
2.___________________________
3.___________________________

List activities or postures that make your symptoms better.
1.___________________________
2.___________________________
3.___________________________

Recent blood pressure:__________

Do you have a Pacemaker?_____ Do you take Vitamin D?_____mg

Please list ALL medications you are currently taking.

Medication	Dosage	Frequency	How Administered
1.			
2.			
3.			
4.			
5.			

Please indicate with a check mark whether you or family members have been told you have.

Condition	You	Family	Condition	You	Family
Cancer			Ulcers/ stomach problems		
Diabetes			Kidney disease		
Heart disease			Gall bladder disorder		
High blood pressure			Bladder disorders		
Low blood pressure			Prostate disease		
High Cholesterol			"Female" organ disorder		
Neurologic disease			Liver disease		
Stroke			Anemia		
Multiple Sclerosis			Asthma		
Seizures			Allergies		
Migraines			Lung disease		
Blood Clot			Emphysema		
Bleeding Disorder			Hepatitis		
Thyroid disease			Depression		
Eating Disorder			Bi-polar disorder		
Osteoporosis			Psychiatric disorder		
Rheumatoid arthritis			Anxiety		
Gout			Chemical Dependency		
Fibromyalgia			Contagious diseases		
Skin disorders			Tuberculosis		

During the past three months, have you experienced any of the following?

Change in general health			Dizziness/ vertigo			Easy Bruising	
Unexplained weight loss or gain			Numbness or tingling			Abnormal stress	
Changes in appetite			Swelling			Headache	
Changes in bowel or bladder function			Fainting			Chest pain	
Fever, chills or sweats			Skin rashes or itching			Stomach/abdominal pain	
Difficulty swallowing			Difficulty sleeping			Head Injury	
Shortness of breath			Confusion			Decreased or little interest in doing things	
Abnormal fatigue			Intolerance to cold			Feelings of depression, hopelessness, being down	
Weakness in both legs			Upper respiratory infection/cold			****For women only**	
Vision changes; blurriness, double vision, spots			Urinary tract infection			Abnormal bleeding/periods	
Abdominal Pain			Nausea/vomiting			Pelvic pain	
Ringing in your ears			Sores or cuts that are slow to heal			Currently pregnant	

Are you allergic to Latex tape or adhesives? Y / N   Are you afraid of falling? Y / N

Have you had any near falls? Y / N   In the last 3 months, have you fallen? Y / N

Patient signature_______________________ **Reviewing therapist**_______________________

Thank you for taking the time to fill out this form