HealthWELL
PHYSICAL THERAPY GROUP

PATIENT HISTORY • Page one of two

Name:_____ Age:_____ Date:_____

Height:_____ Weight:_____ Date of Injury or Surgery:_____

Tell Us About Your Condition

What is your primary complaint?_____

_____

Have you had similar complaints before? ☐ Yes ☐ No If Yes, did you receive treatment this year? ☐ Yes ☐ No

What treatment and by whom?_____

Did it help? ☐ Yes ☐ No Please explain:_____

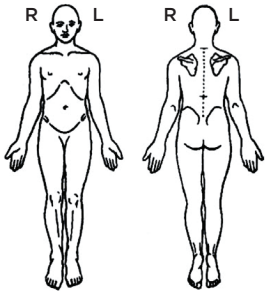
What eases your pain?_____

What aggravates your pain?_____

Do you have night pain? ☐ Yes ☐ No If yes: Does pain wake you when you're: ☐ still ☐ moving ☐ both

As the day progresses are you: ☐ better ☐ worse Are your symptoms: ☐ Constant ☐ Intermittent

Are you: ☐ getting better ☐ staying the same ☐ getting worse



Where is your pain? On the figures to the left, please mark Xs where your CURRENT symptoms are located.

Pain Intensity: On a scale of 1-10, please circle your current pain level:

NO PAIN |← 0 1 2 3 4 5 6 7 8 9 10 →| WORST PAIN

Function: Please list any specific activity limitations you have due to your current problem.

_____

_____

_____

Medical History

Have you been diagnosed with any of the following conditions?

Allergies	☐ Yes ☐ No	Currently pregnant	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Depression	☐ Yes ☐ No	Metal implants	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Dizziness/ringing in ears/vertigo	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Emphysema/Chronic Bronchitis	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Cardiac conditions	☐ Yes ☐ No	Gallbladder problems	☐ Yes ☐ No	Speech problems	☐ Yes ☐ No
Cardiac pacemaker	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Strokes	☐ Yes ☐ No
Chemical dependency	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Circulation problems	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	Vision problems	☐ Yes ☐ No

Have you suffered from any illness not listed here? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Name:_____ Age:_____ Date:_____

Do you have any scars from injury or surgery? ☐ Yes ☐ No If yes, where?_____

Fall History

Is your injury the result of a fall? ☐ Yes ☐ No Have you fallen twice or more in the past year? ☐ Yes ☐ No

Dates of falls:_____

Please list any recent tests for this complaint (X-Ray, MRI, CAT Scan, Blood Work, EMG, etc)

Date:_____ Test:_____

Date:_____ Test:_____

Date:_____ Test:_____

Date:_____ Test:_____

Surgery History

Please list any past surgeries, injuries or conditions for which you have been hospitalized or sought medical attention.

Body Region:_____ Surgery Type:_____ Surgery Date:_____

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Body Region:_____ Surgery Type:_____ Surgery Date:_____

Current Medications

Please list all prescription and over-the-counter medications you are currently taking. Include pills, inhalers, injections and skin patches. We can copy your personal written medication list if you have one.

Drug:_____ Dosage:_____ Reason for Taking:_____

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Health Habits

Do you eat a well balanced diet? ☐ Yes ☐ No Do you drink water regularly? ☐ Yes ☐ No # of glasses each day:_____

Do you have known food allergies? ☐ Yes ☐ No If yes, what are they:_____

Do you exercise regularly? ☐ Yes ☐ No How often? _____ Type/program?_____

Do you smoke? ☐ Yes ☐ No Daily amount?_____ How long have you been smoking?_____

Do you drink caffeinated drinks? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No #/day? _____ Days/week? _____

Goals

Please list and explain your 3 goals for physical therapy:

1]_____

2]_____

3]_____