Physical Therapy & Wellness Center

Updated Health History

Name_____

Date_____

1. **What is the primary complaint you are being seen for? Please be specific and give a brief description.**

   _____

2. **When did this problem begin? (Date, approximate if unknown)** _____

3. **What type of problem is it?**
   - ◯ **a.** New injury
   - ◯ **b.** Previous injury
   - ◯ **c.** Auto injury
   - ◯ **d.** Workers compensation
   - ◯ **e.** Post-surgical, Date of surgery _____
   - ◯ **f.** Other _____

4. **Where did the problem occur?**
   - ◯ **a.** Work
   - ◯ **b.** Home
   - ◯ **c.** Motor vehicle accident
   - ◯ **d.** During recreation
   - ◯ **e.** Competitive sports
   - ◯ **f.** Other_____

5. **Have you had any treatment for this problem prior to today?**
   - ☐ **a.** None
   - ☐ **b.** Surgery
   - ☐ **c.** Chiropractic
   - ☐ **d.** Physical Therapy
   - ☐ **e.** Medication/Injections
   - ☐ **f.** Other_____

6. **Have you had any special tests for this problem?**
   - ☐ **a.** None
   - ☐ **b.** X-Rays
   - ☐ **c.** CT scan
   - ☐ **d.** MRI
   - ☐ **e.** EMG
   - ☐ **f.** Bone scan
   - ☐ **g.** Other_____

7. **Test Results (skip if no tests performed)** _____

8. **What is your employment status?**
   - ◯ **a.** Employed: Position (please write)_____ ◯ Full time ◯ Part time
   - ◯ **b.** Student
   - ◯ **c.** Unemployed
   - ◯ **d.** Retired
   - ◯ **e.** Homemaker
   - ◯ **f.** Disabled

9. **If employed do you have any restrictions at work?** _____

10. **What are your primary job tasks? (Check all that apply)**
    - ☐ **a.** Prolonged sitting
    - ☐ **b.** Prolonged standing
    - ☐ **c.** Lifting
    - ☐ **d.** Repetitive tasks
    - ☐ **e.** Operating a machine
    - ☐ **f.** Driving
    - ☐ **g.** Other _____

11. **What are your exercise habits?**
    - ◯ **a.** None
    - ◯ **b.** Mild (stairs, short walk, golf)
    - ◯ **c.** Occasional (4x/week, less than 30 minutes)
    - ◯ **d.** Regular (4x/week, 30 minutes or more)

12. **Current symptom description (Check all that apply)**
    - ☐ Sharp pain ☐ Dull pain ☐ Burning ☐ Tingling ☐ Dizziness ☐
    - ☐ Nausea ☐ Aching ☐ Numbness ☐ Constant ☐ Intermittent Other_____

13. **Is your pain worse in the** ◯ **morning,** ◯ **mid-day, or** ◯ **night?**

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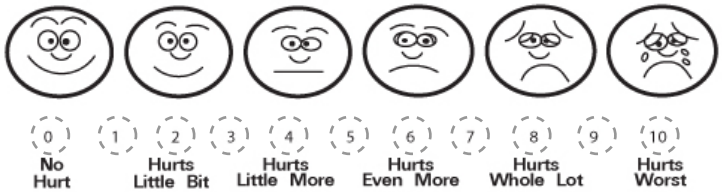
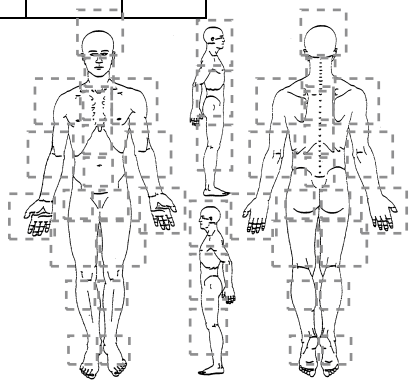
14. On a scale of 0-10 (0 being no pain, 10 being extreme pain) rate your pain?



15. What affects your pain (see chart below)?

	Better	Worse	Same		Better	Worse	Same
Ice	○	○	○	Sleeping	○	○	○
Heat	○	○	○	Lying down	○	○	○
Sitting	○	○	○	Coughing/sneezing	○	○	○
Standing	○	○	○	With activity	○	○	○
Walking	○	○	○	After activity	○	○	○
Rising from sitting	○	○	○	Rest	○	○	○
Position changes	○	○	○				

16. Please mark the body chart with an X in the areas of pain.



17. **Please list any surgeries you have had including implantations**
(i.e. IUD, pacemaker, pain pump, lap band, clips, mesh, staples, etc)

_____ **Date** _____
_____ **Date** _____
_____ **Date** _____

18. Please circle any of the following health conditions that you <u>have or had in the past</u>.

- ☐ **a.** None
- ☐ **b.** Cancer
- ☐ **c.** Diabetes
- ☐ **d.** High blood pressure
- ☐ **e.** Heart problems
- ☐ **f.** Rheumatoid arthritis
- ☐ **g.** Osteoarthritis
- ☐ **h.** Asthma
- ☐ **i.** Emphysema
- ☐ **j.** Over weight
- ☐ **k.** Fibromyalgia
- ☐ **l.** Unexplained weight loss
- ☐ **m.** Chemical dependency
- ☐ **n.** History of fracture
- ☐ **o.** Seizures
- ☐ **p.** Currently pregnant
- ☐ **q.** # of pregnancies
- ☐ **r.** # of deliveries
- ☐ **s.** Thyroid disease
- ☐ **t.** Multiple sclerosis
- ☐ **u.** Hepatitis
- ☐ **v.** Allergies
- ☐ **w.** Tuberculosis
- ☐ **x.** Kidney disease
- ☐ **y.** Anemia
- ☐ **z.** Stroke
- ☐ **aa.** Osteoporosis
- ☐ **bb.** Smoker
- ☐ **cc.** Menopausal
- ☐ **dd.** Incontinence
- ☐ **ee.** Depression
- ☐ **ff.** Mental Illness
- ☐ **gg.** Other _____

19. Please list ALL medications that you are taking and list the dosage. (Please be very specific.)

<u>Medication</u>	**<u>Dosage</u>**
_____	_____
_____	_____
_____	_____