PREMIER PHYSICAL THERAPY

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Health History

Name: _____ Date:____/____/____ Primary Care Physician: _____

Referring MD:_____ Date of Next Appointment:___/___/___ Date Last Seen:____/____/____

Date of onset or injury: _____ If injury:Work Comp_____ MVA____ Other____ Work Status:_____

Chief Complaint: _____

Current Symptoms: □ Pain □ Numbness/Tingling □ Stiffness □ Weakness Condition: □ Acute □ Chronic

List any relevant surgeries, with dates, you have had related to this condition or injury: _____

If you have had any of the following tests done in relation to this condition, list their dates:

X-ray _____ MRI _____ CT Scan _____ Nerve Conduction _____

If you have been treated for this condition before, please explain those treatments.

Height: _____ Weight: _____

Do you have any of the following?

Allergies to medications	Yes	No	Blood Clot/Emboli	Yes	No	Varicose Veins	Yes	No
Allergies to latex/lotion	Yes	No	Epilepsy/Seizures	Yes	No	Gout	Yes	No
Asthma, Bronchitis or Emphysema	Yes	No	Thyroid Trouble/Goiter	Yes	No	Sleeping Difficulties	Yes	No
Shortness of Breath/Chest Pain	Yes	No	Anemia	Yes	No	Psychological Problems	Yes	No
Corornary Heart Disease	Yes	No	Infectious Disease	Yes	No	Bowel/Bladder Problems	Yes	No
Do you have a Pacemaker	Yes	No	Diabetes (Type I or Type II)	Yes	No	Frequent Headaches	Yes	No
High Blood Pressure	Yes	No	Cancer or Chemo/Radiation	Yes	No	Vision/Hearing Problems	Yes	No
Heart Attack/Surgery	Yes	No	Arthritis/Swollen Joints	Yes	No	Dizziness or Faintess	Yes	No
Stroke/TIA	Yes	No	Osteoporosis	Yes	No	Are you pregnant?	Yes	No

Smoking Daily_____ Weekly_____ Alcohol Consumption Daily_____ Weekly_____

Pain when performing the following activities?

	Mild	Moderate	Severe	Unable		Mild	Moderate	Severe	Unable
Bending	_____	_____	_____	____	Reading (Focus)	_____	_____	_____	____
Climb Stairs	_____	_____	_____	____	Self Care-Bathing	_____	_____	_____	____
Driving	_____	_____	_____	____	Self Care-Dressing	_____	_____	_____	____
Kneeling	_____	_____	_____	____	Self Care-Shaving	_____	_____	_____	____
Lifting	_____	_____	_____	____	Sexual Activities	_____	_____	_____	____
Pet Care	_____	_____	_____	____	Extended Computer Use	_____	_____	_____	____
Sleeping	_____	_____	_____	____	Sitting (Prolonged)	_____	_____	_____	____
Walking	_____	_____	_____	____	Carrying Groceries	_____	_____	_____	____
Yard Work	_____	_____	_____	____	Standing (Prolonged)	_____	_____	_____	____
Feeding (Self)	_____	_____	_____	____	Household Chores	_____	_____	_____	____
Lift Children	_____	_____	_____	____	Care for Infirm Family	_____	_____	_____	____
					Change Pos (Sit to Stand)	_____	_____	_____	____

Sports:_____

Recreational Activities:_____ Exercise Habits: Daily_____Weekly_____

Other relevant Medical Condition: _____

Please list current medications (if you have a list we can copy)

Medication	Dosage	Frequency	Route	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Life Style & Goals

Occupation:_____ Physical demands:_____

Hobbies:_____ Active Level: □ Very □ Somewhat □ Sedentary

What are your goals for therapy?_____

What makes your pain better and/or worse?_____