



PATIENT HEALTH HISTORY

Patient Name _____ Clinic _____ Date _____

List medications you are currently taking _____

CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fracture/Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuromuscular	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dizziness/Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood Clots/Vascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bladder/Bowel Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pregnancies # _____ Dates _____			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____			
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	_____				

SURGICAL	YES	NO	DATE	Please Describe
Joint Replacements	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Orthopedic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Fracture Reductions	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Joint Manipulations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Spinal Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other Surgeries			_____	_____

Please list your current limitations/restrictions _____

DIAGNOSTICS	YES	NO	DATE	Results
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
EMG Nerve Studies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

PAIN/SYMPTOMS

Please mark your pain on an average day by marking a number on the scale below.

0 _____ 10
 No Pain ER Visit

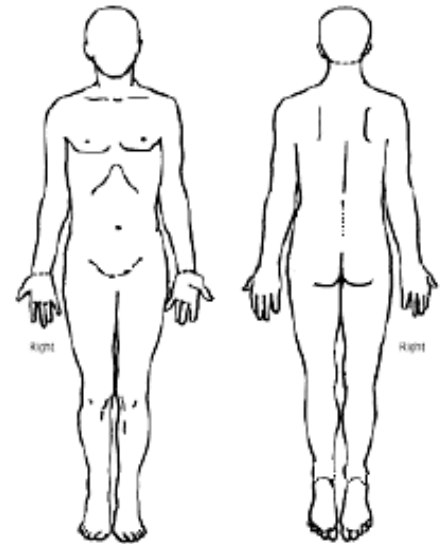
On the Body Diagram to the right, describe your symptoms using the following symbols:

(X) Sharp (+) Numb/Tingling (#) Ache (B) Burning

Have you received PHYSICAL/OCCUPATIONAL THERAPY for this injury before? Yes No

If yes, please list date _____

If yes and Medicare patient, please contact billing representative.



Have you had two or more falls in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a fall in the past year that resulted in injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Signature _____ Date _____

Legal Guardian _____ Date _____