Colleyville Physical Therapy & Sports Rehab

Southlake Sports & Spine Rehab

Date:_____

OT PATIENT HEALTH HISTORY

Patient Name: _____DOB: _____ Primary Care Physician:_____

Gender: M F **Age:** ____ **Smoker/Tobacco User:** Y N **Pregnant:** Y N

Do you have a pacemaker? Y N **Are you latex sensitive?** Y N

Occupation: _____

Describe your regular workout routine: _____

Medication allergies you may have:_____

Have you ever taken steroid medications for any medical conditions? Y N

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Y N

PAST MEDICAL HISTORY:

Past surgical history (list all and date): _____

Have you RECENTLY noticed any of the following (check all that apply)?

- ☐ Fatigue
- ☐ Numbness or tingling
- ☐ Constipation
- ☐ Fever/chills/sweats
- ☐ Muscle weakness
- ☐ Diarrhea
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Shortness of breath
- ☐ Weight loss/gain
- ☐ Heartburn/indigestion
- ☐ Fainting
- ☐ Difficulty with balance
- ☐ Difficulty swallowing
- ☐ Cough
- ☐ Falls
- ☐ Changes in bowel or bladder function
- ☐ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Depression
- ☐ Thyroid problems
- ☐ Heart Problems
- ☐ Lung problems
- ☐ Diabetes
- ☐ Chest pain/angina
- ☐ Tuberculosis
- ☐ Osteoporosis
- ☐ Bladder/Urinary tract infection
- ☐ High blood pressure
- ☐ Asthma
- ☐ Multiple Sclerosis
- ☐ Circulation problems
- ☐ Rheumatoid arthritis
- ☐ Epilepsy
- ☐ Blood clots
- ☐ Other arthritic conditions
- ☐ Eye problem/infection
- ☐ Stroke
- ☐ Ulcers
- ☐ Anemia
- ☐ Kidney problem/infection
- ☐ Liver problems
- ☐ Bone or joint infection
- ☐ Sexually transmitted disease/HIV
- ☐ Hepatitis
- ☐ Chemical dependency (alcoholism)
- ☐ Pelvic inflammatory disease
- ☐ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart Problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ High blood pressure
- ☐ Depression
- ☐ Blood clots

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

What activities are most limited: _____

Do you have any barriers to learning or participating in occupational therapy? If so, please list:

_____

Fall Risk: Have you had any falls in the past year YES NO How Many?_____ Do you have a fear of falling **YES NO**

For Therapist Use Only

Any signs of elder maltreatment? **YES NO**

Reviewed with patient on _____ _____

Date Signature

Height: _____Weight: _____ Therapist Initials: _____