Colleyville Physical Therapy & Sports Rehab

Date:_____

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: _____
Are you on a work restriction or any other restriction from your doctor? _____
Describe your regular workout routine: _____
List any 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)

- ☐ Alzheimer
- ☐ Cancer
- ☐ Dementia
- ☐ 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**

CURRENT SYMPTOMS

Chief Complaint - please list how and when symptoms began:_____

_____

_____

My symptoms are currently: **GETTING BETTER / ABOUT THE SAME / GETTING WORSE**

Have you received any treatment for this problem? _____

If so what type of treatment (medication, injections, chiropractic)? _____

Did this treatment affect your symptoms? _____

Have you had an X-ray, MRI, or other imaging study? If so when? _____

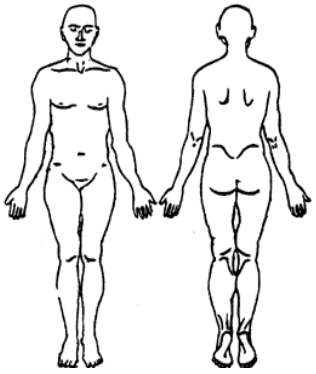
Have you ever had this problem before? **YES NO** If so, when? _____ Treatment received _____

_____

BODY CHART

Please mark the areas where you feel symptoms on the chart to your right with the following symbols to describe your symptoms.

- ^ **Shooting/sharp pain**
- **O Dull/aching pain**
- **lll Numbness**
- **= Tingling**



On the scales below, please circle the number that best represents the severity of your pain.

Average for the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Aggravating Factors: Please list what activities and positions (standing, sitting, laying down) make your symptoms worse**:**

_____

Easing Factors: Please list what activities and positions (standing, sitting, laying down) make your symptoms better**:**

_____

How do your symptoms affect your ability to sleep?

☐ **No problem sleeping** ☐**Difficulty falling asleep** ☐ **Awakened by pain** ☐ **Sleep only with medication**

When are your symptoms worst? ☐**Morning** ☐**Afternoon** ☐**Evening** ☐**Night** ☐**After Exercise**

When are your symptoms best? ☐**Morning** ☐**Afternoon** ☐**Evening** ☐**Night** ☐**After Exercise**

How much do your symptoms limit your overall functional ability?

Unable to Function 0 1 2 3 4 5 6 7 8 9 10 **Function without Limitations**

What activities are most limited: _____

What is your desired outcome(s) from physical therapy: _____

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

_____

For Therapist Use Only

Reviewed with patient on: (date) _____ (signature)_____