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: _____

Are you on a work restriction or any other restriction from your doctor? _____

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)?

- ☐ Alzheimer / Dementia
- ☐ 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**

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** When_____ Treatment received_____

_____

How do your symptoms of pain, numbness and tingling 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 occupational therapy: _____

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?_____

Were you injured in a fall?_____

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: _____