



Patient Health History Form

Name: _____ **Date:** _____

Injury/onset Date: _____ **If Unknown When Did Symptoms Begin?** _____

Was Surgery Performed? Yes No (If yes) Date: _____ **Type:** _____

Diagnosis/Condition _____

History of fall in the Past 12 Months? Yes No (If yes) How Many Times? _____

Did You Hurt Yourself? _____

How Did This Condition/Injury Begin? _____

Prior to this Injury, Were you Independent in the Following Areas?

- Yes No Activities of Daily Life
- Yes No Self Care
- Yes No Work/Vocation
- Yes No Care giving
- Yes No Mobility/Ambulation
- Yes No Community Integration/Access

Do you Work Full Time? Yes No Has the Injury Changed your Ability to Work? Yes No

Which Functional Limitations apply to you: Circle all that apply

- Sleep
- Self care
- ADL's (Activities of Daily Life)
- Reaching, Pushing, or Pulling
- Lifting/Carrying
- Sitting/Standing
- Bending/Squatting
- Mobility/Ambulation
- Community Integration/Access
- Other _____

Main Complaints:

What Improves the Condition: _____ ?

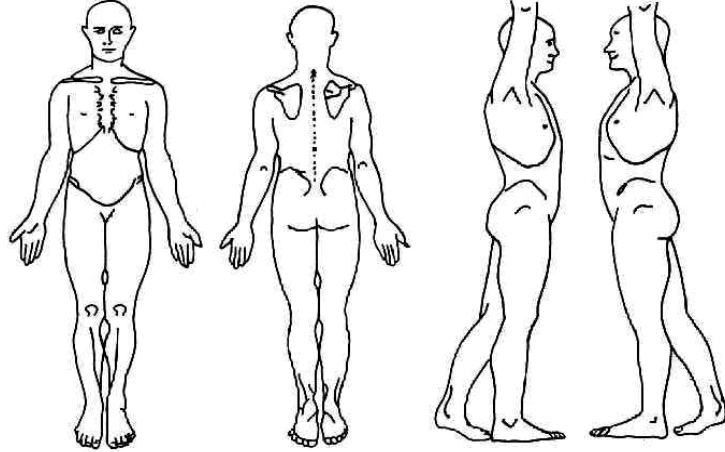
What Worsens the Condition: _____ ?

Pain Scale: In the last 48 hours

	No Pain		Little		Medium		Large		Worst Possible Pain		
	0	1	2	3	4	5	6	7	8	9	10
Worst											
Best											
Current											

Type of Pain Experienced:

- Burning
- Dull/Achy
- Throbbing
- Shooting
- Numbness/Tingling
- Other _____



Pain Location: (Mark on Diagram →
Where You Have Pain or Other Symptoms)

Are the Symptoms Constant or Intermittent? _____

Medical History (When and Where):

- Osteoarthritis _____
- Cardiovascular Diseases _____
- Diabetes Mellitus Type 1 _____
- Diabetes Mellitus Type 2 _____
- Surgical History _____
- Previous Therapy _____
- Other _____

Any Diagnostic Testing (X-rays, MRI, NCS, Other)? _____

Current Medications:

- Prescription(s) _____
- Over the Counter _____
- Herbals _____
- Vitamins/Minerals/Dietary Supplements _____
- Other _____
- No Medications _____

Patient Goals:

Body Mass Index:

Weight _____ lbs
Height _____ inches