

Patient History Form Page One

Patient Name _____ Date _____

What medical concerns can we assist with today?

Primary care physician: _____ Primary's phone # _____
Referring provider: _____ Provider's phone # _____

Are you currently receiving physical therapy? (Y/N)

Current Medications

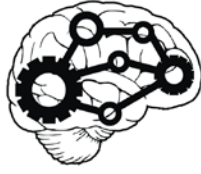
Medication	Dose (mg/mcg)	Number of times taken daily

Are you allergic to any medications? Yes No
If yes, to which medications and what type of reaction? _____
Are you allergic to any foods? Yes No
If yes, to which foods, and what type of reaction? _____
Do you have any environmental allergies? Yes No
If yes, to what and what type? _____

Social History

Do you currently smoke or chew tobacco? Yes No
If yes, how many packs per day? _____ How many years have you been smoking? _____
If no, have you in the past? Yes No How many years did you smoke? _____
Do you drink alcohol, beer, or wine? Yes No
If yes, how many years have you or did you drink? _____
If no, have you in the past? Yes No How many drinks per week? _____
Have you ever used an illicit drug? Yes No If yes, what have you used? _____

If you still use, do you feel this is a problem Yes No
Do you currently drink coffee, pop, tea, or energy drinks? Yes No
Do you exercise daily/weekly? Yes No
Do you feel you have social support Yes No
What is the highest education level you have completed? _____
What do you do for a living? _____
What are your domestic responsibilities? _____
What are your hobbies/recreational activities? _____



Patient History Form Page Two

Patient initials _____

What are your goals for treatment or what activities would you like to be able to do that you have trouble doing now because of your condition? (Please list 2-3) _____

Have you have had any of these symptoms recently? (Please circle)

- | | | | |
|---------------------|------------------------|---------------------|--------------------------|
| Cough | Change in vision | Sinus pain | Leg cramps |
| Shortness of breath | Swollen/painful joints | Allergy symptoms | Heartburn |
| Thoughts of suicide | Headache | Breathing problems | Diarrhea |
| Light sensitivity | Dizziness | Chest pain | Nausea/vomiting |
| Decreased hearing | Fainting | Palpitations | Rash |
| Abdominal pain | Sound sensitivity | Pain with urination | Urinating frequently |
| Back pain | Difficulty urinating | Constipation | Memory difficulty |
| Neck pain | Foot/ankle pain | Numbness | Trouble sleeping/snoring |
| Sore Throat | Swollen lymph nodes | Weakness | Recent Weight Loss/Gain |
| Fatigue | Sexual dysfunction | Hoarseness | Tingling |
| Depression | Anxiety | Loss of taste | Walking difficulty |
| Double vision | Swallowing difficulty | ringing in the ears | Loss of consciousness |
| Speech difficulty | Loss of smell | | |

Females: Gynecological History

Are you pregnant? (Y/N)

Do you get any symptoms that seem to occur regularly with your period (Y/N)

If yes, please explain _____

Which of the following medical conditions do you have or have had in the past?

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Migraines | <input type="checkbox"/> Head/neck trauma |

Please describe any current or past medical conditions not listed above:

Please list your past surgeries

Family History

	<u>Living</u>	<u>Age(s) (or age at death)</u>	<u>List illnesses</u>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
List other family members and their illnesses			
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____