Patient History Form

Name: _____ Phone # _____

Cell phone#: _____ Email: _____

Appointment date: _____ Date of birth: _____

Rate your health:
Excellent/Good/Fair/Poor

Emergency Contact Name and Number:_____

_____

Gender:_____ _____

Past Medical History: Have you ever been told you have any of the following? If so when…

Cancer	Yes	No	Blood clots	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression/Anxiety	Yes	No	Other _____		

Please explain if you are currently experiencing problems with any of the above:

_____

_____

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Changes in bowel or bladder function	
Dizziness	Nausea/vomiting	Night pain	Headaches

How have you been sleeping at night? Fine / Disturbed / only with medication

During the past month, have you been bothered by feeling down, depressed or hopeless? Y / N

During the past month, have you had little interest or pleasure in doing things? Y / N

What date (approximately) did your present symptoms start? _____

How? (gradually, suddenly, injury) _____

How have your symptoms changed? getting better about the same getting worse

What makes your symptoms better? _____

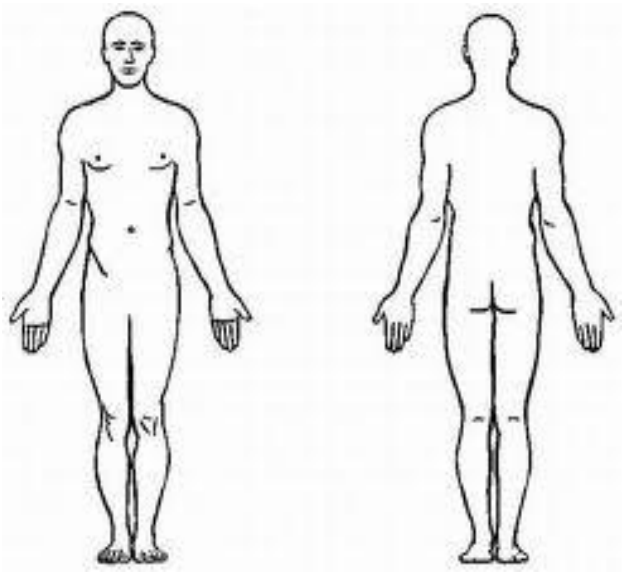
What makes your symptoms worse? _____

Have you had an X-ray, MRI, or other testing for this problem? No / Yes (specify) _____

What treatments have you received for this problem so far? _____

Body Chart:
Mark the areas where
you feel your symptoms.

Mark an X where you feel pain
Mark with /// if you feel numbness or tingling



On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0 1 2 3 4 5 6 7 8 9 10
Cannot do anything — Able to do everything

Aggravating Factors: Identify up to 3 important activities that you are unable to do or have difficulty with because of your problem.

1) _____
2) _____
3) _____

During the past 6 months, have you fallen? If yes, please describe and report how many times.

_____

_____

List any other injuries as well as surgeries you have had that have required medical attention (including broken bones).

_____

_____

What are your personal goals for therapy? (be specific) _____

_____

Please provide us with a list of current medications used over the last 3 months including the dosage amount. Please include over the counter medications and supplements you take as well. You may provide your own written copy.

Medication_____Reason for taking_____

Medication_____Reason for taking_____

Medication_____Reason for taking_____

Medication_____Reason for taking_____

Medication_____Reason for taking_____

Medication_____Reason for taking_____

Medication_____Reason for taking_____

Medication_____Reason for taking_____

I have been given the opportunity to review the Active PT and Wellness's Notice of Privacy Practices for Protected Health Information regarding my rights to privacy as a patient.

Please initial: _____

CONSENT: My diagnosis and treatment plan will be discussed with me by the physical therapist during my appointment and I understand that I have the right to question and/or refuse any treatment offered. I attest that the information that I have provided above is accurate and complete.

_____ _____

(signature) (date)

Parent signature if patient is a minor
