Patient Health Information

Name: ____ DOB: ____________________

Please put a check in the box next to any medical conditions you may have, or have had in the past.

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Polymyalgia
- ☐ Lupus/SLE
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Osteoporosis
- ☐ Headaches/Migraines
- ☐ Bulging Disks
- ☐ Leg Cramps
- ☐ Jaw Pain/TMJ
- ☐ History of Falls
- ☐ Cane/Walker/Crutches
- ☐ Other: ________________

Circulation/Respiration
- ☐ Heart Conditions
- ☐ Heart Attack
- ☐ Heart Arrhythmias
- ☐ Pace Maker
- ☐ High Cholesterol
- ☐ Blood Clots/Phlebitis
- ☐ Anemia
- ☐ Other: ______________

Infectious Disease
- ☐ TB
- ☐ Hepatitis
- ☐ Polio
- ☐ Other: ______________

Digestion
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Irritable bowel
- ☐ Bladder Problem
- ☐ Liver Problem
- ☐ Hernia
- ☐ Other: __________

Skin
- ☐ Skin Allergies/Rashes
- ☐ Eczema/Psoriasis
- ☐ Infectious Skin Diseases
- ☐ Shingles
- ☐ Other: ___________

Nervous System
- ☐ Stroke/TIA
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Epilepsy/Seizures
- ☐ Concussion/Brain Injury
- ☐ Numbness/Tingling
- ☐ Other: ________________

Please list any other prior accidents, broken bones or surgeries with approximate dates: ____________________________
____
____
____

1. Have you had surgery for this injury? ☐ YES ☐ NO If yes, Surgery date(s): ____________________________

2. When did pain begin? (Date of Injury) ____

3. Have you had any Medical or Rehabilitative services for this injury/episode? ☐ YES ☐ NO

4. Are you currently taking any prescription or non-prescription medications? If so please list them: ______________
____
____

5. List any other information that would assist us in your care: ______________________________________
____

6. Are you aware of what your diagnosis is? ____
7. Based upon your awareness, what are your expectations/goals while in Therapy? ________________________
____
____

Do you smoke? ☐ YES ☐ NO Are you pregnant? ☐ YES ☐ NO

____ ____________________
Patient/Guardian Signature Date

I have reviewed contraindications with ______________________ prior to initiating evaluation and treatment. The following contraindications were identified:
I have reviewed with ______________________________ their rehabilitation potential prior to initiating treatment.
Therapist Signature: ____________________________________ Date: ______________________