

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What condition prompted you to come to physical therapy? \_\_\_\_\_

How has your condition limited your ability to function? \_\_\_\_\_

### Health History

(Please circle all that apply)

- |                             |                           |                              |
|-----------------------------|---------------------------|------------------------------|
| 1. Heart Disease or Stroke  | 11. Depression            | 21. Psychological Problem    |
| 2. High Blood Pressure      | 12. Diabetes Mellitus     | 22. Anorexia                 |
| 3. High Triglycerides       | 13. Obesity               | 23. Bulimia                  |
| 4. Cancer                   | 14. Arthritis             | 24. Compulsive Overeater     |
| 5. Lung/Pulmonary Disease   | 15. Anemia                | 25. Other Medical Issues     |
| 6. Kidney Disease           | 16. Food Allergies        | 26. Currently Pregnant       |
| 7. Osteoporosis             | 17. Neuromuscular Disease | 27. Currently Breast Feeding |
| 8. Ulcer                    | 18. Arteriosclerosis      | 28. Monitored by Physician   |
| 9. Gastrointestinal Disease | 19. Gallbladder Disease   | 29. Require High Level Care  |
| 10. Diarrhea                | 20. Constipation          | 30. Special Diet             |

If yes, please explain: \_\_\_\_\_

List any medications that you are currently taking: \_\_\_\_\_

Please indicate (by circling the appropriate numbers) your average & worst pain level last week.

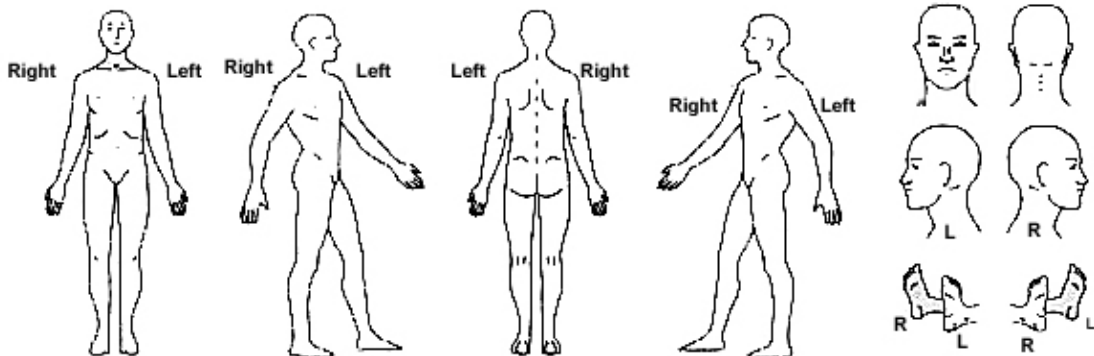
1 2 3 4 5 6 7 8 9 10  
NO PAIN WORST PAIN

Is the pain you are experiencing (Please Circle)

Constant

Intermittent/Comes & Goes

Circle the Word(s) That Best Describes the Pain You Are Experiencing  
Sharp, Ache, Throbbing, Burn, Dull, Numbness, Tingling or Other: \_\_\_\_\_



Body Chart – Draw in where you feel the pain lately