Health History Form

Date _____

Please read all Bold Headings; circle or fill in all words that apply to your past history or present symptoms. Please inform your therapist if there are any additions to this history form during your care.

Name _____Date of Birth _____

Weight _____ Height _____ R / L Handed _____

Whom may we thank for recommending you to OUTER BANKS PHYSICAL THERAPY ?
_____

List your chief complaint and health problems that you would like addressed
_____

_____

Is this complaint work or MVA related? _____
Aggravating Factors: Sitting, coughing, walking, exercise, rest _____
Alleviating Factors: Sitting, walking, exercise, rest _____
Have you had any falls in the past year? _____ If so, how many? _____
Please explain: _____
_____
_____

Pain Scale

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

Date of latest complete exam _____ Health Care Provider _____
_____

Medications: Circle and list all prescription and non-prescription; include dosages.
Aspirin, Ibuprofen, Coumadin, Prednisone (present / previous dose _____
and duration in weeks _____)

Other Medications: _____
_____
_____

Do you take supplements? _____ Which ones? _____

Allergies: Medications, food, exercise, other. (List reactions such as hives, rash, shock, tongue swelling, breathing difficulty, etc. _____
_____
_____

Surgery – Please list; including dates_____
_____
_____

Imaging, X-rays, MRI CT (Specify by name and date of studies and results if known) _____
_____
_____

Exercise When injury free(list recent activities, frequency and duration. Also list future goals _____
_____
_____

Infection: History of TB, bone, heart valve, kidney, chronic lung, abscesses, skin, hepatitis B, C HIV/AIDS, Lymes
Circle if recent: Temperature, chills, night sweats, rash _____
_____

Lung: History of Asthma, Bronchiectasis, TB, Pneumothorax, Lung diseases, hoarseness, pain worse with a deep breath, other
_____
_____
_____

Heart: History of Heart Attack, Angina, valve disorder, Arrhythmia, -fast, slow, cardiac arrest, implantable defibrillator, pacemaker, congestive heart failure IHSS, Cardiac Hypertrophy, Myocarditis, heart transplant, bypass surgery, high blood pressure.
Circle if recent symptoms of: Chest, arm, jaw pain with exercise, palpitations, fainting, other _____
_____
_____
_____

Describe and detail any of the above _____
_____
_____
_____
_____

Blood Vessels: Deep vein Thrombosis, Arteriosclerosis of leg vessels, artery bypass surgery.
Circle if recent symptoms of: Calf pain with walking, enlargement of calf or thigh, cold legs, leg or calf pain at rest. _____
_____
_____

Gastrointestinal: Ulcer, Appendix surgery, Gall Bladder stones, infection, Colitis, Crohns disease ___

_____
_____
Circle if recent symptoms: Nausea, vomiting, belly pain, diarrhea, bloody stool, change in stools, swallowing difficulties, other _____
_____
_____

General: Chronic Fatigue Syndrome _____
Circle if recent symptoms: Fatigue, weakness, insomnia, weight loss or gain, other _____
_____
_____

Kidney: Kidney Infection, kidney stone _____
Circle if recent symptoms: Pain with urination, facial swelling, no urination for 24 hours, loss of urine control _____
_____
_____

Reproductive Organs: Males Prostate infection, hernia _____
_____

Females: Birth control pills, Ovarian cysts, Endometriosis, latest period or menopause date _____, Ectopic pregnancy, presently pregnant _____
Circle if recent symptoms: Excessive vaginal bleeding, pelvic pain _____
_____

Hormonal: Thyroid condition, Osteoporosis, Osteomalacia, Osteopoenia, diabetes (year of onset) ____
_____

Rheumatologic: Rheumatoid arthritis, fibromyalgia, lupus, Sjogrens, Scleroderma, Psoriatic arthritis, Ankyklosing Spondylitis, Reiter Syndrome _____
Circle if recent symptoms: Joint swelling or deformity, muscle aching _____

Neurologic; Seizure, Multiple Sclerosis, Guillain-Barre Syndrome, ALS, Disc Bulge _____
_____

Skin: Cellulitis, Psoriasis, Hives, painful cyst, rash, red streaks _____
_____
_____

Spine/Orthopedic/Bones: Fracture, dislocation, neck/back problem, motor vehicle injury, rickets, Ehlers-Danlos, _____
_____
_____

Drug Abuse: Pain medication, cocaine, other, anxiety drugs, alcohol use _____
_____
_____
_____

Psychiatric: Depression, panic attack, psychotic disorder, borderline disorder, suicide attempt _____
_____
_____
_____

Cancer/Blood: List any cancers and dates _____
Anemia, bleeding disorder _____
_____
_____

Describe and detail any of the above _____
_____
_____
_____

What are your goals for recovery?_____
Increase in movement _____
Increase in strength _____
Return to work _____
Return to sports _____
Other _____

Have you had Physical Therapy visits this year at another facility? If yes, how many visits and at which facility (name). _____
_____
_____

Signature _____

Date _____