

HEALTH HISTORY

To ensure you receive a complete and thorough evaluation, please answer the following questions the best you can. Ask your therapist to assist if you need help of do not understand a question.

Name: _____

Circle YES or NO...

Have you or any immediate family member ever been told you have:.....

	<u>Self</u>	<u>Family</u>
Cancer	Yes...No	Yes....No
Diabetes	Yes..No	Yes....No
High blood pressure	Yes..No	Yes....No
Heart disease	Yes...No	Yes....No
Angina/chest pain	Yes...No	Yes....No
Stroke	Yes...No	Yes....No
Osteoporosis	Yes..No	Yes....No
Osteoarthritis	Yes...No	Yes....No
Rheumatoid arthritis	Yes...No	Yes....No

Do YOU have a history of:

Allergies/Asthma	Yes....No
Headaches	Yes....No
Bronchitis	Yes....No
Kidney disease	Yes....No
Rheumatic fever	Yes....No
Ulcers	Yes....No
Multiple Sclerosis	Yes....No
Seizures	Yes....No
Head Injury.....	Yes..No
Chemical Dependency.....	Yes..No
Parkinsons.....	Yes..No
Lymphedema.....	Yes..No

In the past 3 months have you had or do you experience:

A change in <u>your</u> health?.....	Yes....No
Nausea/Vomiting ?.....	Yes....No
Fever/chills/sweats ?.....	Yes....No
Unexplained weight change ?.....	Yes....No
Numbness or tingling ?.....	Yes....No
Changes in appetite ?.....	Yes....No
Difficulty swallowing ?.....	Yes....No
Changes in bowel/bladder function...	Yes....No
Shortness of breath ?.....	YesNo
Dizziness ?.....	Yes....No
Upper respiratory infection ?.....	Yes....No
Urinary tract infection ?.....	Yes....No

Are you currently:

Pregnant ?.....	Yes....No
Depressed ?.....	Yes....No
Under Stress ?.....	Yes....No

Are your symptoms: (check one)

Getting worse The same Improving

How are you able to sleep at night? (check one)

Fine
Moderate difficulty
Only with medication

Check all that apply...

Do you have a problem with ... (check all that apply)

Hearing Vision
Speech Communication

Do you or have you in the past smoked tobacco?

YES NO

If yes, _____ Packs **X** _____ Years.
Last tobacco use _____

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week

Do you have a cardiac pacemaker? YES NO

If yes, inserted when? _____

Please check if you are allergic to:

Latex Tapes/adhesives
Cortisone
Food/
Other: _____

Have you ever been in a relation ship where you have been hurt or threatened?

YES NO

Do you feel safe at home?

YES NO

Are you currently seeing chiropractor?

YES NO

Are you currently receiving home health services?

YES NO

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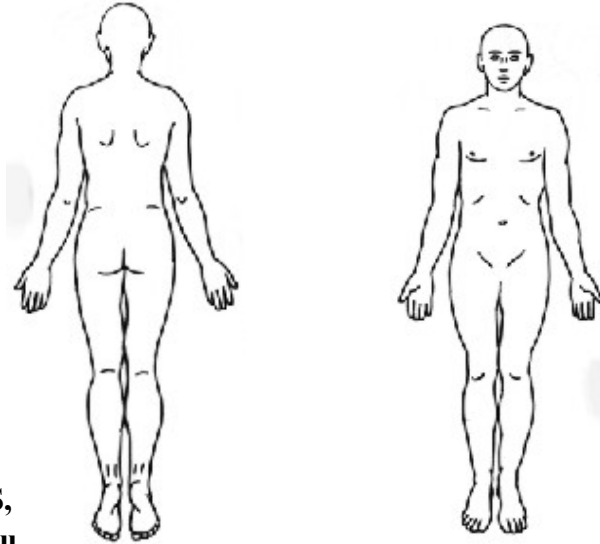
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Have you had any physical or occupational therapy visits in the past year?..... YES NO
About how many? _____
When (Approximate)? _____

Do you have an advanced directive?
YES NO

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY:
Pins & Needles = 000
Stabbing = ////
Burning = XXX
Deep Ache = zzz



Please list any **SURGERIES, INJURIES, or OTHER CONDITIONS** for which you have received medical care and approximate date:

MEDICATIONS:

Please list or check current medications you are taking?

- Prescribed pain medication
- Over the counter pain pills
- Muscle relaxants
- Anti-inflammatory
- Blood pressure medication
- Blood thinner
- Heart medication
- Cholesterol medication
- Diabetic medication
- Thyroid medication
- Inhalers

Other:
