Health History

Name:			
Preferred Name / Nickname:			
Birthdate:	Age:	Height:	Weight:
Dominant Hand: ☐ Right ☐ Left		Gender:	
Referring Provider:		Date of Initial Injury:	
Occupation:		Date of Surgery:	

Known Allergies:	**Latex Allergy: ☐ YES**
Have you fallen in the past year? ☐ Yes ☐ No	
Reason for today's visit:	
Medical treatments for current injury:	
How did your injury occur?:	

RIGHT LEFT LEFT RIGHT

BACK

Mark your symptoms on the figure to the left:	
"S" on sharp	"#" on burning
"X" on dull pain	"N" on numbness

Please rate your pain level: 0=No Pain 5=Moderate pain 10=Worst possible pain	
Currently?	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Best in last 24h?	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Worst in last 24h?	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What helps the pain?	
What makes the pain worse?	

Please identify three important activities that are difficult due to your current problem.
Then, rate your ability to do these activities in the last week by circling the appropriate number.

	0 = unable to perform 10 = able to perform fully
Activity:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Activity:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Activity:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
How many days per week do you get 30 or more minutes of moderate **physical activity?**	**☐ None ☐ A Few Days ☐ Most Days**
Do you have access to workout equipment?	**☐ Yes ☐ No**
What type of activity do you prefer? (i.e. cardiovascular, weightlifting, etc.)	

Have you had imaging for current injury? ☐ X-ray ☐ MRI ☐ Other________________________

Past Medical History (Please check all that apply)

- ☐ Aids/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Incontinence
- ☐ Kidney Trouble
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Thyroid Disorder
- ☐ Other:_______________

Have you experienced any of the following since injury/surgery?

- ☐ Changes in appetite
- ☐ Changes in bowel or bladder function
- ☐ Depression
- ☐ Dizziness
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Nausea/vomiting
- ☐ Night Pain
- ☐ Numbness/tingling
- ☐ Pelvic pain
- ☐ Poor balance/falls
- ☐ Shortness of breath
- ☐ Unexplained weight loss or gain
- ☐ Other:_______________

Surgical History	Dates

Please list all current medications, supplements or vitamins	Reasons for Taking	Dosage

Do you live alone? ☐ Yes ☐ No If yes, do you have assistance at home?__________________________
Do you have limiting barriers (i.e. stairs) at home? ☐ Yes ☐ No If yes, please explain____________