Patient Health History Form

Today's Date: ____________________________

Name ___________________________________ Date of Birth _______________ Age _________
Address: ____
Phone: ____
Email: ____
Emergency Contact: Name _________________________________ Relationship _____________
and Phone ______________________
Referring Physician ___________________________ Primary Physician _______________________

Current Chief Complaint or Functional Limitation:

____

____

When did this problem begin? ____
Initiating cause of problem or injury? ____

Interventions for this problem thus far? (any therapy, surgery, massage, etc?)

____

____

Experience from previous interventions? (what helped, did anything make worse, no change?)

____

____

What physical activity do you do regularly? ____

____

____

Daily Activities that you CANNOT perform because of pain or functional limitation from this problem: ____

____

What is (are) your **GOAL(s)** for therapy? What would you like for me to be able to help you be able to do?

____

____

Current meds, vitamins and/or supplements you are taking, or are prescribed to take:

Name of Product	Prescription or OTC	Dosage Amount and frequency	Reason for medication	complaint?

ALLERGIES TO MEDICATIONS

Name of medication or ingredient	Type of Reaction?

Past Medical History (diagnoses, and approximate date diagnosed)

Diagnosis	Date Diagnosed (or approximate)

Notes: ____

____

Past Surgical History

Surgery, (including Right or Left, if appropriate)	Date	Surgeon/Location	Any complications?

Any internal electrical devices? (Pacemaker, Brain/Spinal Stimulator, Diabetic Pump?) __________
Notes: ____

For those with Scoliosis, Kyphosis, Scheurmann's, or hypokyphosis:

Current Cobb angles and location if known (example thoracic, lumbar) ____________________

____

Thoracic Kyphosis angle (side view), if known ____

Lumbar Lordosis angle (side view), if known ____

What bothers you most about your posture? ____

____

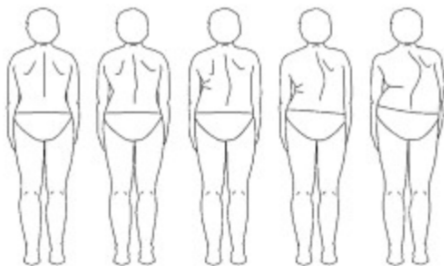
Risser score, if known ___________

Year or age of start of menstruation if applicable: __________________________________

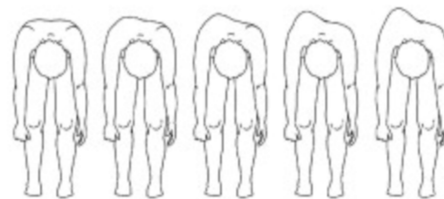
History of Bracing:

Date (from when to when?)	Type or name of brace	#hours/day told to wear	Level of compliance (Always, Most, Some, or Not a Chance)

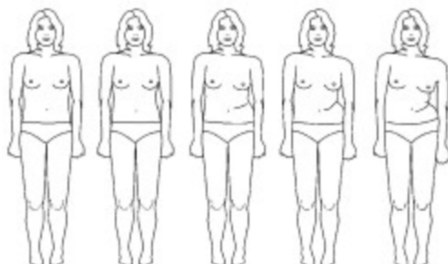
Please circle the images below as to how you feel it most accurately resembles your current physical presentation. For set 3, you only need to circle respective to your gender.



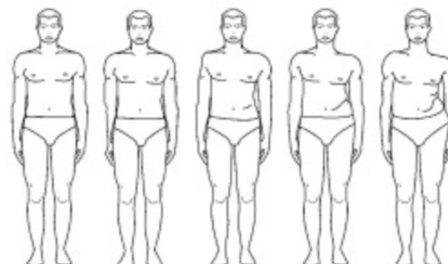
SET 1



SET 2



SET 3 (females)

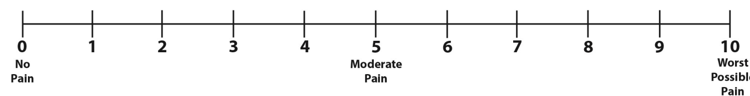


SET 3 (males)

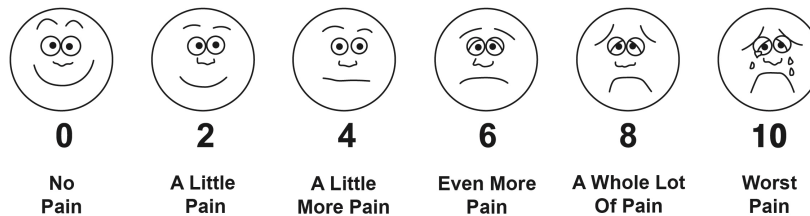
For ALL Clients: Pain Section

- Do you have any pain associated with the current problem ? ______________________________
- Does the pain radiate or refer to other areas? __________ If so, where and when? __________
____
- Please mark on the diagram location and type of pain.
- Does pain wake you in the middle of the night? ____
- Does pain limit your ability to get comfortable in bed? (different than above question) ______
- What makes the pain better? ____
- What makes the pain worse? ____
- How would you rate the pain on a scale of 1-10? (You can include a range - best to worst)

Numeric Rating Scale



Wong-Baker FACES® Pain Rating Scale



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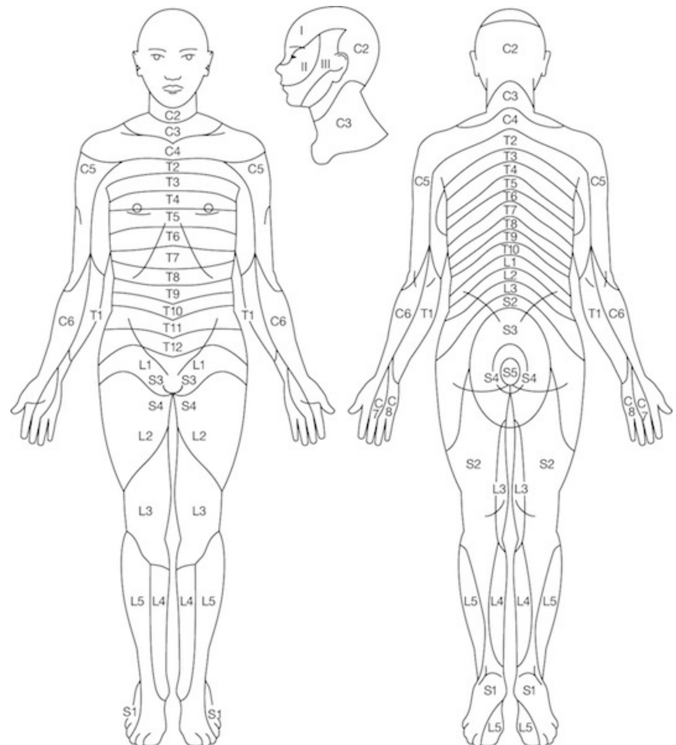
- What is your goal for pain relief considering the above scale? ____________________________

Please denote pain or abnormal sensation on the image to the right.

x = pain
☆ = numbness
T = tingling/pins & needles

Please circle pain description:

stabbing
throbbing
dull
achy
sharp
shooting/radiating
pulling



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Thank you for taking the time to share this essential information!