



Name: _____
 DOB: _____ Age: _____
 Today's Date: _____
 Chart #: _____

Client History Information

****Please fill out to the best of your ability and focus on what is pertinent to your visit with us today****

General Health Status

Please rate your health: Excellent Good Fair Poor
 Exercise: None Moderate Daily Heavy Athlete
 Health Habits: Smoking Alcohol Water Coffee/Caffeine Stress
 Any Major Life Changes in the Last Year? (eg, new baby, job change, death in the family) Yes No
 If yes, please describe: _____

Family History

Please list if your father, mother, sibling, aunt/uncle or grandparent has had any of the following conditions and the age of onset if known.

Arthritis: _____	Cancer: _____
Diabetes: _____	Heart Disease: _____
Hypertension: _____	Osteoporosis: _____
Psychological: _____	Stroke: _____
Other: _____	Other: _____

Medical/Surgical History Please check if you have ever had:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Parkinsons
<input type="checkbox"/> Cancer	<input type="checkbox"/> Infectious Disease (TB, Hepatitis)	<input type="checkbox"/> Repeated Infections
<input type="checkbox"/> Circulation/Vascular Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Depression	<input type="checkbox"/> Low Blood Sugar/Hypoglycemia	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Developmental/Growth Issues	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes/High Blood Sugar	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Ulcers/Stomach Problems

Other: _____

Broken Bones/Fractures (include dates)

Surgeries (include dates)

_____/_____/_____
 _____/_____/_____

_____/_____/_____
 _____/_____/_____

Allergies: _____

Supplements/Herbs: _____

Medications: _____

MEDICARE PATIENTS ONLY

Height* _____ Weight* _____

**Have you fallen 2 or more times in the past year? Yes / No

**In the past year, have you fallen and sustained an injury due to that fall? Yes / No

Employment/Recreation

Are you: A Student Employed Unemployed A Homemaker Retired

Hobbies/Sports: _____

Current Employment: Occupation _____ Part-time Full-time

Work Activity: None Sitting Standing Light Labor Heavy Labor

Out of Work Due to Injury?: No Yes, please describe: _____

Work Restrictions?: No Yes, please describe: _____

Current Condition/Chief Complaint

Reason for Visit: _____

Is this condition: A New Problem A Chronic Problem Unknown

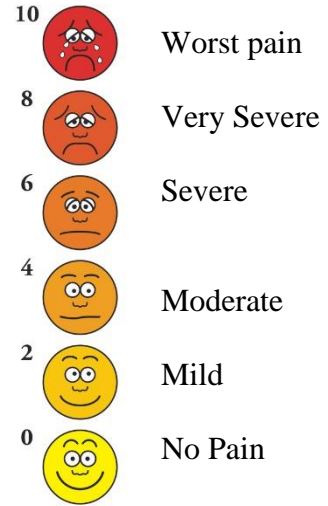
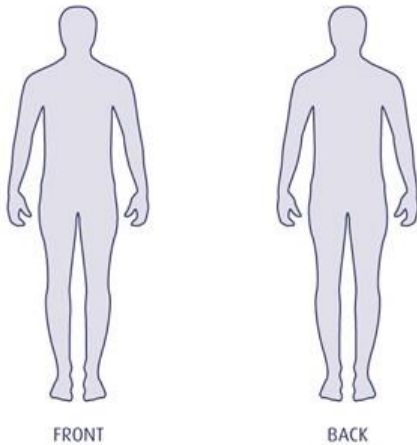
When did symptoms appear?: _____ Is it getting worse?: Yes No Unknown

What makes the problem(s) better?: _____

What makes the problem(s) worse?: _____

What are your goals for physical therapy?: _____

Please circle the location of your pain or where you may be having difficulty functioning, and circle your level of pain on the right.



Are you seeing anyone else for the problem(s)?: Please check all that apply

- Acupuncturist Cardiologist Chiropractor Dentist
- Family Practitioner Internist Massage Therapist Neurologist
- OBGYN OT Orthopedist Osteopath
- Pediatrician Podiatrist Primary Care Dr. Rheumatologist
- Other: _____

Is your problem(s) affecting your daily activities?: Please check all that apply

- Bed Mobility Walking Driving Recreation
- Shopping Household Care Dependent Care Self Care (bathing, dressing etc)

Patient/Guardian Signature: _____ **Date:** _____