

Patient Health History and Information

Date: ___/___/___ **Name:** _____ **Sex:** M F **Acct. #** (office use only): _____

Age: _____ **Height:** _____ **Weight:** _____ **Dominant hand:** R L **Could you be or are you pregnant:** Yes No

Reason for Therapy: _____

Please describe how your injury occurred (i.e. fall, activity, work, auto): _____

Date of injury or onset of symptoms: ___/___/___ **Recent surgery?** Yes No **Date:** ___/___/___ **Type:** _____

Please list any treatment you have received for this condition (i.e. Therapy, Chiropractor): _____

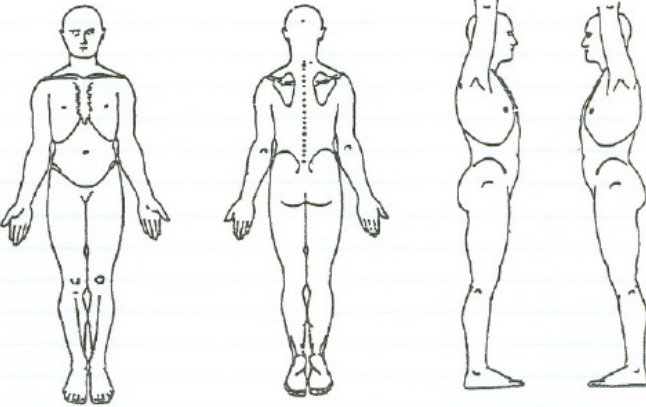
For this condition have you had any of the following? None X-ray ___/___/___ MRI / CT scan ___/___/___

Injection: type: ___/___/___ **Surgery:** type: ___/___/___ **Other:** ___/___/___

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain // = Numbness

O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0 1 2 3 4 5 6 7 8 9 10
At worst:	0 1 2 3 4 5 6 7 8 9 10
At best:	0 1 2 3 4 5 6 7 8 9 10

Please describe your pain/symptoms

Constant	Intermittent	Increasing
Decreasing	Staying the same	
Sharp	Dull	Aching
Weakness	Throbbing	Other: _____

What makes your symptoms worse? (i.e. heat, cold, rest, activity) _____

What makes your symptoms better? (i.e. heat, cold, rest, activity) _____

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Cancer	Self	Family	No	Thyroid problems	Self	Family	No
High blood pressure	Self	Family	No	Epilepsy/dizziness	Self	Family	No
Heart trouble/angina	Self	Family	No	Tuberculosis	Self	Family	No
Diabetes	Self	Family	No	Anemia/blood disorder	Self	Family	No
Stroke	Self	Family	No	Multiple Sclerosis	Self	Family	No
Osteoporosis	Self	Family	No	Circular/vascular problems	Self	Family	No
Osteoarthritis	Self	Family	No	Chemical dependency	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Depression	Self	Family	No	AIDS/HIV	Self	Family	No
Headaches	Self	Family	No	Hepatitis	Self	Family	No
Bladder/bowel problems	Self	Family	No	Other: _____	Self	Family	No

Please list prescription / over the counter medications you are currently taking: _____

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No	Unexplained weight change	Yes	No
Nausea / Vomiting	Yes	No	Night sweats / pain	Yes	No
Numbness genital/anal area	Yes	No	Problems with vision / hearing / speech	Yes	No
Dizziness / Fainting	Yes	No	Difficulty with bowel/bladder function	Yes	No
Unexplained weakness	Yes	No	Other: _____	Yes	No
Headaches	Yes	No			

Rate your overall health: Excellent Good Average Poor **Do you exercise?** Yes No ___x/week

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No ___/week

Date: ___/___/___ Name: _____

Acct. # (office use only): _____

Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/ Heavy lifting Other: _____

Employer: _____ Current work duty: Full duty Restricted duty Work days missed: _____

QRC (if you have one): _____

Please indicate your current limitations due to injury:

___ Sitting: _____ ___ Standing: _____ ___ Sleeping: _____
___ Going from sit to stand ___ Walking _____ ___ Lying down ___ Up/Down stairs
___ Reaching _____ ___ Squatting ___ Bending ___ Looking overhead
___ Taking a deep breath ___ Swallowing ___ Talking / Chewing / Yawning / All (circle one)
___ Turning head ___ Driving ___ Work
___ Self care / Hygiene _____ ___ Home activities _____
___ Repetitive activities _____ ___ Sports / Recreation _____
___ Other: _____

What are your goals for therapy? _____

Who referred you to Physical Therapy? _____

Primary Physician: _____

How did you hear about OSI Physical Therapy? Physician Friend/relative Website Previous patient

Self Coach Other: _____

Please list anything else that you would like us to know about you: _____

Patient Signature: _____ Date ___/___/___

Reviewed by Therapist: _____ Date ___/___/___

MD follow-up: ___/___/___ None Scheduled

With-in 90days of last Medical history completion

– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature: _____ Date ___/___/___

Reviewed by Therapist: _____ Date ___/___/___