Health History Please complete and sign

Name:_____ Date:_____

Height_____ Weight_____

Date of Injury/Problem:_____/ Injury or Area_____

Surgery Date:_____ Next Dr. Appointment:_____

Describe Previous treatment for this condition:_____

Does pain awaken you at night? Y N

Unexplained weight Loss? Y N

Do you smoke? Y N

Are you feeling a high level of stress or anxiety? Y N

Do you have difficulty with depression? Y N

Have you had any falls in the last month? Y N If yes how often in a week? _____ Month? _____

List Medications you take _____

Allergies to medications/ food_____

Do you have? or ever had (Please circle those that apply to you)

Dizziness, Night pain, numbness, weakness, shortness of breath, bowel / bladder control problems, poor circulation/ bruising, artificial joints. Are you pregnant? _____Diabetes, Cancer _____, High blood pressure, arthritis, asthma, stroke, fainting, Osteoporosis, HIV, Hep A,B,C.

How would you rate your pain? (0 no pain/ 10= severe pain)

Now_____ at best_____ worst_____

What activities are difficult for you? (Circle all that apply) Sleeping, bed mobility, dressing, bathing, sitting, standing, bending/ lifting, housework, computer, stairs, running, jumping, other_____

What are you physical goals?_____

Initial_____