

# Patient Health History

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To ensure you receive a complete and thorough evaluation, please provide us with the important information concerning your health history requested on this form. If you do not understand a question, please ask your therapist.

Full Name \_\_\_\_\_ LAST 4 SSN \_\_\_\_\_

Occupation / Job Duties: \_\_\_\_\_

**ALLERGIES:** List any medication(s) you are allergic to: \_\_\_\_\_

Are you latex sensitive? (Circle one) YES NO

Other allergies: \_\_\_\_\_

Have you declared the Advanced Clinical Directive of Do Not Resuscitate (DNR)? (Circle one) YES NO

Please check ( ) any of the following whose care you are currently under:

\_\_\_\_ Medical Doctor (MD)      \_\_\_\_ Psychiatrist/Psychologist      \_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_ Osteopath      \_\_\_\_ Physical Therapist      \_\_\_\_\_  
\_\_\_\_ Dentist      \_\_\_\_ Occupational Therapist      \_\_\_\_ Chiropractor  
\_\_\_\_ Home health in the last sixty (60) days

If you have seen any of the above medical specialists during the past three (3) months, please describe for what reason (illness, injury, medical condition, physical problems, etc) \_\_\_\_\_

## Details of Current Problem:

Date of Injury or Illness: \_\_\_\_\_ Date of Next Physician Appointment: \_\_\_\_\_

Please describe your injury/symptoms which required you coming to Physical Therapy Works. If accident related (work/automobile/other), please give details:

Were any X-Rays taken? (Circle One) Yes No Where? \_\_\_\_\_

Were any MRIs performed? (Circle One) Yes No Where? \_\_\_\_\_

## During the past month:

Have you been feeling down, depressed, or hopeless? (Circle one) YES NO

Have you been bothered by having little interest / pleasure in doing things? (Circle one) YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

(Circle one) YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? (Circle one) YES NO

Are you, or will you be, trying to get pregnant during the course of your therapy?

(Circle one) YES NO

Please complete the other side of this form.

**Previous Medical History:** (Circle one) YES NO

YES	NO	Heart Problems / Chest Pain / Pressure
YES	NO	High / Low Blood Pressure
YES	NO	Varicose Veins / Circulatory Problems
YES	NO	Allergies/Wheezing/Asthma
YES	NO	Alcoholism / Chemical Dependency
YES	NO	Thyroid Problems
YES	NO	Diabetes/ Insulin Dependent
YES	NO	Multiple Sclerosis
YES	NO	Rheumatoid Arthritis
YES	NO	Other Arthritic Conditions / Bone Problems
YES	NO	Nervous Breakdown / Depression
YES	NO	Hepatitis Type: A B C
YES	NO	Tuberculosis
YES	NO	Other Communicable Disease
YES	NO	Stroke Date _____
YES	NO	Kidney Problems / Disease
YES	NO	Anemia / Other Blood Disorders
YES	NO	Epilepsy / Convulsions / Seizures
YES	NO	Back Problems
YES	NO	Osteoporosis
YES	NO	Severe Headaches
YES	NO	Vision Impairment
YES	NO	Hearing Difficulties
YES	NO	Speech Impairment
YES	NO	Fainting/Dizzy Spells
YES	NO	Stomach Ulcer
YES	NO	Hernia or Rupture
YES	NO	Bowel Problems / Disease
YES	NO	Menstruation Problems/Difficulties
YES	NO	Skin Allergies/Disease
YES	NO	Pregnant Date: _____
YES	NO	Cancer: Type _____

**FOR OFFICE USE ONLY**

**Please list any surgeries or other conditions for which you have been hospitalized.**

	Date	Surgery / Condition
a		
b		
c		

**Please describe any significant injuries for which you have been treated** (fractures, dislocations, sprains, etc).

	Date	Surgery / Condition
1		
2		
3		

*Please complete the next page of this form.*

**Has anyone in your immediate family** (parents, brothers, or sisters) **ever been treated for any of the following?** (Circle one) YES NO

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Tuberculosis	YES	NO	Arthritis
YES	NO	Heart Disease / Problems	YES	NO	Anemia
YES	NO	High / Low Blood Pressure	YES	NO	Headaches
YES	NO	Stroke	YES	NO	Epilepsy / Convulsions / Seizures
YES	NO	Kidney Disease	YES	NO	Mental Illness
YES	NO	Alcohol / Chemical Dependency			

**Which of these over-the-counter medications have you taken in the past week?**

(Circle one) YES NO

YES	NO	Aspirin
YES	NO	Tylenol
YES	NO	Advil / Motrin / Ibuprofen
YES	NO	Laxatives
YES	NO	Decongestants
YES	NO	Antihistamines
YES	NO	Antacids
YES	NO	Vitamins / Minerals / Supplements
YES	NO	Herbals

**FOR OFFICE USE ONLY**

**Please list all prescription medications you are currently taking** (pills, injections, patches, etc).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**How many cups of caffeinated coffee, tea, or other beverage do you drink per day?** \_\_\_\_\_ cups

**Do you smoke?** (Circle one) YES NO **If YES,** (Circle one) Cigarettes Cigars Pipe

**If Yes, how many packs of cigarettes, or how many cigars do you smoke per day?** \_\_\_\_\_

**How many days per week do you drink alcohol?** \_\_\_\_\_

**If one drink equals one glass of beer, one glass of wine, or one shot of liquor, how many drinks do you have at an average sitting?** \_\_\_\_\_

**How many days per week do you use marijuana, cocaine, crack, acid, etc?** \_\_\_\_\_

**Have you recently noted?** (Circle one) YES NO

YES	NO	Weight gain or loss
YES	NO	Nausea or vomiting
YES	NO	Fatigue / Tired
YES	NO	Weakness
YES	NO	Fever / Chills / Sweats
YES	NO	Numbness or Tingling

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date