## **CASCADE PHYSICAL THERAPY**

## **HEALTH HISTORY FORM**

\*Please read all bold headings, circle or fill in all words that apply to your past or present symptoms.

\*Please inform your therapist if there are any additions to your history form during your care.

									Sex:		1	F	
Age:Height:	:Weight:				R	igh	t Ha	nded				Hande	d
	Date												
Chief Complaint: (inclu	uding location & symptor	ms): _											<del></del>
Rate your pain:	No pain							-Excrı	ciating	g pai	in		
	0 1 2 3	4	5	6 7	8	9	10						
When did pain begin?													
How did pain begin? (A	Auto accident, work related	l injur	y, gr	adual or	nset, t	trau	mati	c injur	y, surge	ery,	lifting	g, pulli	ng, slip/fa
A wa viou annumently would	king? Y/N Light duty _		711 á		000								
	tting, coughing, walking, e												
	itting, walking, exercise, re												
	rescription and non-prescr												
mercang p	rescription and non preser	iption	r ara;	S <sup>3</sup> )·									<del></del>
Allergies (to medication	and other irritants):												
	cedures):												
													<del>_</del> _
Imaging (X-rays, MRI,	CT scan, other test, area of	the b	ody,	dates a	nd res	sults	if k	nown)	:				
Exercise when injury-fi	ree (list recent activities, fr	requei	ncy,	as well a	as fut	ure	goal	s):					
	ency and duration):												
Have you been to physi	cal therapy before?												
Have you been to physi Past Medical History (C	cal therapy before? Check all that apply to you.						heet			info	ormat	ion)	
Have you been to physi Past Medical History (C Infection/Disease:	cal therapy before?Check all that apply to you. Lung:	use t	the b art:	ack side	of th		heet Ur	inary	}			Neur	ologic:
Have you been to physi Past Medical History (C Infection/Disease:Bone infection	cal therapy before?Check all that apply to you. Lung:Asthma	Hea	the b art: Hear	ack side	of th		heet Ur	inary: Kidne	: y Stone	es		Neur Se	izures
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Therapist's Signature \_\_\_\_\_Patient's Signature \_\_\_\_\_