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.**

Name: _____Date: _____ Sex: M F
Age: _____Height: _____Weight: _____ Right Handed Left Handed
Physician: _____Date of last visit with Physician: _____
Chief Complaint: (including location & symptoms): _____
_____
Rate your pain: No pain----------Excruciating pain
0 1 2 3 4 5 6 7 8 9 10
When did pain begin? _____
How did pain begin? (Auto accident, work related injury, gradual onset, traumatic injury, surgery, lifting, pulling, slip/fall)
_____
Are you currently working? Y/N Light duty ___ Full duty ___ Occupation _____
Increased pain with: sitting, coughing, walking, exercise, rest, other: _____
Decreased pain with: sitting, walking, exercise, rest, other: _____
Medication (including prescription and non-prescription drugs): _____
_____
Allergies (to medication and other irritants): _____
Surgery (Dates and procedures): _____
_____
Imaging (X-rays, MRI, CT scan, other test, area of the body, dates and results if known): _____
_____
Exercise when injury-free (list recent activities, frequency, as well as future goals): _____
_____
Aerobic exercise (frequency and duration): _____
Have you been to physical therapy before? _____ When and where? _____
Past Medical History (Check all that apply to you, use the back side of this sheet for additional information)

Infection/Disease:	**Lung:**	**Heart:**	**Urinary:**	**Neurologic:**
___Bone infection	___Asthma	___Heart Attack	___Kidney Stones	___Seizures
___Abscess	___TB	___Pacemaker	___Incontinence	___MS
___Hepatitis (B,C)	___Pneumothorax	___Valve disorder	___Urinary Tract	___ALS
___HIV/AIDS	___Pulmonary	___Arrhythmia	Infection	___Guillian-Barre
___Lyme disease	Hypertension	___Congestive Heart	___Other: _____	___Other: _____
___Recent fever, chills	___Pulm. Embolus	Failure	_____	_____
or night sweats	___Chronic cough	___Cardiac	**Reproductive:**	**Skin:**
___Other: _____	___Shortness of breath	Hypertrophy	Men:	___Cellulitis
_____	___Other: _____	___Heart Transplant	___Prostate surgery	___Psoriasis
	_____	___Other:_____	___Hernia	___Scleroderma
Cancer: (affected	**Gastrointestinal:**	_____	Women:	___Other: _____
tissue and dates):	___Ulcer	**Blood Vessels:**	___Endometriosis	_____
_____	___Appendectomy	___Deep vein	___Ovarian Cysts	**Orthopedic:**
_____	___Gall Bladder	thrombosis	___Pregnancy	___Fractures
Hormone:	___Colitis	___Arteriosclerosis	Due date: _____	___Dislocations
___Hyperthyroid	___Crohns	___Bypass surgery	___Other _____	___Surgery:_____
___Hypothyroid	___Other: _____	___Anemia	_____	_____
___Osteoporosis	_____	___Hypertension	**Diabetes:**	**Psychological:**
___Other: _____		___Other: _____	___Diabetic	___Emotional
_____		_____	___ Insulin	___Specific: _____
			Dependent	_____

Therapist's Signature _____Patient's Signature _____

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