

majerus & co. physical therapy

INITIAL PATIENT HEALTH HISTORY

Patient Name: _____ Birth Date: _____

Primary Care Physician: _____ Today's Date: _____

Primary concern:

Accident Injury Chronic Condition Surgery or Procedure Recent Illness Other

Reason for your visit _____

Occupation: _____ Date of injury/onset: _____ Affected side: R / L / Both

Specific place injury occurred: _____

Hospitalization or Other treatment to date: _____

Activities that have been affected: _____

Pain rating _____ (0=no pain, 10=worst imaginable): Worsening/alleviating factors: _____

Medical History: Please check all that apply or add pertinent information not listed. If N/A, check NONE

- | | | |
|--|--|--|
| <input type="checkbox"/> Alzheimer's / Dementia | <input type="checkbox"/> Headaches / TMJ | <input type="checkbox"/> Psychiatric condition |
| <input type="checkbox"/> Autoimmune: Lupus/HIV/Other: _____ | <input type="checkbox"/> History of Cancer: _____ | <input type="checkbox"/> Pulmonary: Asthma / CHF |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Skin Problem |
| <input type="checkbox"/> Bowel/Bladder problem | <input type="checkbox"/> Implanted devices: _____ | <input type="checkbox"/> Sleep condition |
| <input type="checkbox"/> Cardiac: Heart Attack/Arrhythmia | <input type="checkbox"/> Infectious disease: _____ | <input type="checkbox"/> Stomach problem |
| <input type="checkbox"/> Cardiovascular: Hypertension/Stroke | <input type="checkbox"/> Learning/developmental disabilities | <input type="checkbox"/> Thyroid/Hormone condition |
| <input type="checkbox"/> Diabetes Type I / Type II | <input type="checkbox"/> Muscular disorder: _____ | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Difficulty Walking / Falls | <input type="checkbox"/> Neuro: Parkinson's /Seizures /Other | <input type="checkbox"/> Vein issues |
| <input type="checkbox"/> Fracture/Sprain: _____ | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Weight: Obesity/Anorexia |
| <input type="checkbox"/> Gynecologic problem: _____ | <input type="checkbox"/> Osteoarthritis: Spine / joint | <input type="checkbox"/> Wounds, current/previous |

Other: _____

Height: _____ Weight: _____ If female, are you or could you be pregnant? Yes No

Please indicate frequency of use: Tobacco _____ Alcohol _____ Other drugs _____

Surgical History:

If N/A, check NONE

Please list all surgeries and/or procedures performed within the last 12 months, including **month and year**. Please also include any, from previous years, that would relate to your visit here today.

Imaging History:

If N/A, check NONE

If you have had diagnostic imaging related to your present illness or injury, please list **WHAT** type of imaging (i.e. X-Ray, MRI, CT), **WHEN** it was done (month/year), and **WHERE** it was performed (place of service).

Known Allergies:

If N/A, check NONE

Please check if you (or a caregiver) are allergic to: Latex Adhesives

Have you had any of the following in the past year?

If N/A, check NONE

- | | | |
|--|---|--|
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Multiple Injuries | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Sensory Issues | <input type="checkbox"/> Loss of Coordination or Strength | <input type="checkbox"/> Unusual Nausea |
| <input type="checkbox"/> Unusual Cough | <input type="checkbox"/> Unusual Stress (Litigation/Life Events) | <input type="checkbox"/> Swallowing Difficulties |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Concerns about work/other activities worsening current condition | |

Current Medications:

If N/A, check NONE

Please list all medications (prescription, over the counter, herbals, supplements) **including dosage** below:

Goals for Treatment Please describe how we might best address your health concerns:

***If you have questions about this form, or have additional information you would like to share with your therapist, please bring it to their attention during your visit. Please fill out a feedback form in our lobby regarding your experience at any time. Thank you!**