majerus & co. physical therapy

INITIAL PATIENT HEALTH HISTORY

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Primary Care Physician: _____

Primary concern:

☐ Accident ☐Injury ☐ Chronic Condition ☐ Surgery or Procedure ☐ Recent Illness ☐ Other _____

Primary area of chief concern: _____

Occupation:_____ Date of onset or injury:_____ 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 factors: _____

_____ Alleviating factors: _____

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

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

Other medical history not listed above: _____

_____

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**. 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 **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

COVID-19: ☐ Vaccinated ☐ Unvaccinated ☐ Prefer not to answer ☐ Past COVID infection

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

If N/A, check ☐ NONE

☐ Fever/Chills/Sweats
☐ Sensory Issues
☐ Unusual Cough
☐ Loss of Balance
☐ Multiple Injuries
☐ Loss of Coordination or Strength
☐ Unusual Stress (Litigation/Life Events)
☐ Concerns about work/other activities worsening current condition
☐ Shortness of Breath
☐ Unusual Nausea
☐ Swallowing Difficulties

Current Medications:

If N/A, check ☐ NONE

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

_____

_____

_____

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. Thank you!