Adults

Health History Form

Date: _____

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Circle your preferred pronouns *(Optional)*: She/Her He/Him They/Them Other: _____

Occupation: _____ Employer:_____

Email address: _____

Would you like to receive email notifications regarding important clinic announcements and news? ☐ Yes ☐ No

Primary Doctor: _____ Are you pregnant: Y N Trimester: _____ Who is your OB-GYN: _____

Primary Problem/Symptom(s) - *Give us details about what happened and what's going on!*: _____

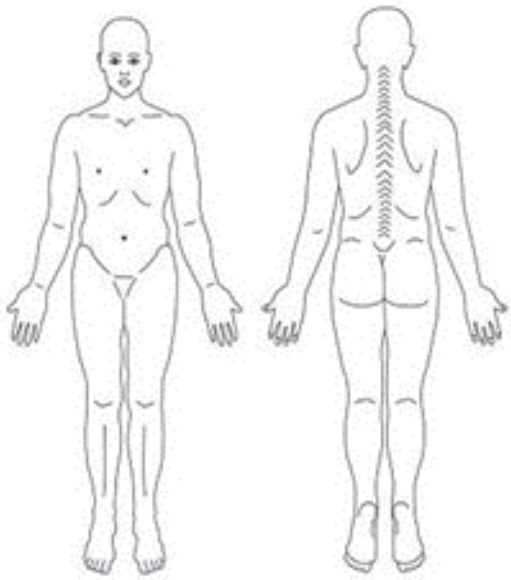
_____

_____

Side of Injury: ☐Left ☐Right Have you had a similar injury? _____

How long has this been bothering you? _____

Please circle or shade areas where you have pain:



Describe your pain:

☐ Burning ☐ Sharp ☐ Achy/Dull

Does your pain wake you up at night? ☐ Yes ☐ No

Please rate your pain at ***rest***:

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain with ***activity***:

0 1 2 3 4 5 6 7 8 9 10

What eases your symptoms? _____

What activities are limited by this injury? _____

What are your goals for physical therapy? _____

Have you had tests for this condition? ☐ X-Ray ☐ MRI

If yes, results: _____

Have you attended physical therapy before? ☐Yes ☐ No

If yes, where and how long ago? _____

_____

Are you seeing any other Health Care Providers for this condition? ☐ Yes ☐ No

☐ Chiropractor ☐ Massage Therapist ☐ Acupuncturist ☐ Other:_____

Please continue on back page

Medical History / Allergies / Surgeries (Check all that apply) :

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Bowel/Bladder
- ☐ Brain Injury
- ☐ Chest Pain
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Menopause
- ☐ Migraines
- ☐ Spinal Surgery
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Seizures
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Trauma/MVA
- ☐ Other: _____

☐ High Blood Pressure - If yes, how is it being managed?_____
_____

☐ Anxiety - If yes, are you receiving treatment? Please describe: _____
_____

☐ Depression - If yes, are you receiving treatment? Please describe: _____
_____

☐ Cancer (please give more details re: diagnosis/treatment): _____
_____
_____

List Surgeries: _____
_____
_____

List Allergies: _____
_____

Current Medications & Supplements List

If you have a medication list, please bring it with you and we can make a copy.

Prescription and Over the Counter

Name

_____
_____
_____
_____
_____
_____
_____
_____
_____

Vitamins / Minerals / Herbal Supplements

Name

_____
_____
_____
_____
_____
_____
_____
_____
_____