

**EDMONDS PHYSICAL THERAPY  
& SPORTS REHABILITATION P.S.**

PATIENT HEALTH HISTORY

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

DIAGNOSIS / REASON FOR PHYSICAL THERAPY: \_\_\_\_\_

PLEASE CHECK IF YOU HAVE SOUGHT CARE FROM ANY OTHER MEDICAL PROVIDERS FOR THIS PROBLEM:

◇ E R ◇ Medical Specialist ◇ Massage ◇ Acupuncture ◇ Chiropractor ◇ PT/OT ◇ Other \_\_\_\_\_

**Due to recent changes in federal healthcare regulations, please answer these following questions**

Is this treatment related to: Workers Compensation Claim (Y)(N); Litigation (Y)(N)

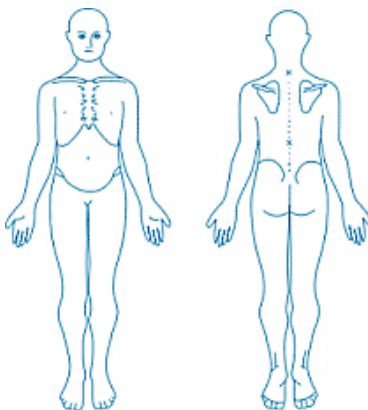
**RECENT DIAGNOSTIC TESTS:** ◇ X-ray ◇ MRI ◇ CT scan ◇ Bone Scan ◇ Blood Tests ◇ EMG ◇ Other \_\_\_\_\_

PLEASE RATE YOUR **PAIN** ON THE FOLLOWING SCALE (0 = NO PAIN AND 10 = WORST PAIN POSSIBLE):

Your pain: **RIGHT NOW:** No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**LOWEST ← → HIGHEST:** No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

PLEASE INDICATE WHERE YOUR PAIN / SYMPTOMS ARE LOCATED:



PATIENT SPECIFIC FUNCTIONAL SCALE

Please list 3 important activities that you are unable to do or are having difficulty doing as a result of your condition:

<u>Please List 3 Activities</u>	<i>(Unable)</i>	<u>Please Rate Your Ability to Perform Your Activities</u>	<i>(No Limitation)</i>
1. _____	0	1 2 3 4 5 6 7 8 9 10	
2. _____	0	1 2 3 4 5 6 7 8 9 10	
3. _____	0	1 2 3 4 5 6 7 8 9 10	

PLEASE LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS:

MEDICATION	DOSAGE	REASON FOR TAKING

MEDICATION	DOSAGE	REASON FOR TAKING

PLEASE LIST ANY ALLERGIES: \_\_\_\_\_

**PLEASE CHECK ANY PAST OR PRESENT CONDITIONS**

PLEASE ANSWER THESE SPECIFIC QUESTIONS WITH A "✓" MARK			
	NEVER	PAST	PRESENT
<b>AUTO – IMMUNE</b>			
<b>Fibromyalgia / Chronic Fatigue</b>			
<b>Gout</b>			
<b>Lupus</b>			
<b>Lyme Disease</b>			
<b>Multiple Sclerosis</b>			
<b>Rheumatoid Arthritis</b>			
<b>CANCER</b>			
<b>Any Type: _____</b>			
<b>NEUROLOGIC</b>			
<b>Numbness/Tingling      Legs</b>			
<b>Weakness                      Legs</b>			
<b>Bowel/Bladder Abnormalities</b>			
<b>Infections</b>			
<b>Recent Weight Loss or Gain</b>			
		PAST	PRESENT
<b>CARDIOVASCULAR</b>			
Chest Pain / Angina			
Heart Disease / CAD			
Heart Attack / MI			
Heart Murmurs / Palpitations			
High Blood Pressure			
Pacemaker			
<b>ENDOCRINE / METABOLIC</b>			
Diabetes / Hypoglycemia			
Thyroid Dysfunction			
<b>GASTROINTESTINAL</b>			
Acid Reflux			
Colitis / Diverticulitis / IBS / Crohn's			
Ulcers			
<b>IMMUNOLOGIC / INFECTIOUS DISEASE</b>			
Hepatitis A, B, or C			
Herpes			
HIV / AIDS			
Shingles			
Tuberculosis			

NEUROLOGIC II	PAST	PRESENT
Coordination Difficulties /Falling		
Numbness/Tingling      Arms		
Weakness                      Arms		
Vertigo/Ringing in Ears/Dizziness		
Headaches		
Parkinson's		
Seizure Disorder / Epilepsy		
Stroke / TIA		
Head Injury/Concussions		
<b>PULMONARY</b>		
Asthma		
Chronic Cough		
COPD / Bronchitis / Emphysema		
Shortness of Breath		
<b>VASCULAR / BLOOD DISORDERS</b>		
Anemia		
Bleeding or Clotting Disorders		
Deep Vein Thrombosis (DVT)		
Peripheral Vascular Disease (PVD)		
Swelling of Hands or Feet		
Varicose Veins		
<b>MUSCULOSKELETAL</b>		
Fracture /Dislocation		
Metal Implants / Pins		
Osteoporosis		
Sprain / Strain		
Tendonitis / Bursitis		
<b>GENERAL / OTHER</b>		
Alcohol / Substance Abuse		
Fainting, Lightheadedness		
Hernia		
Kidney Problems		
Liver Disease		
Pregnant		
Smoke		
Vision Difficulty / Glasses / Contacts		
OTHER (please fill in):		
<b>MENTAL HEALTH</b>		
Depression		
Anxiety		
Bipolar / Schizophrenia / PPD		

SURGERIES OR HOSPITALIZATIONS (past or recent): \_\_\_\_\_

*To the best of my knowledge, the information above is complete and accurate.*

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank-you!!