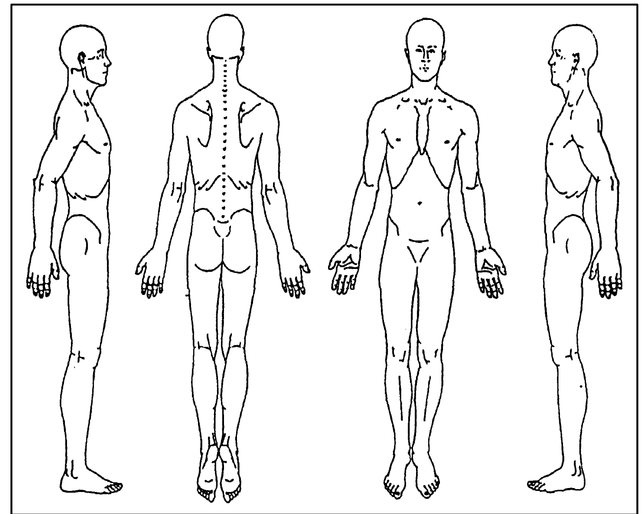
PATIENT HEALTH INFORMATION FORM

TODAY'S DATE _____/_____/**20**_____

DRAW BELOW: MARK PAINFUL AREA/S WITH AN "X"



Height______'______" Weight__________#

REASON FOR TODAY'S VISIT:

1. Primary current complaint or problem we are seeing you for today:
____
____

2. Date when current injury / surgery / problem began?
____

3. Briefly describe how did current injury or problem occur?
____
____
____

4. Did you have a recent X-Ray and/or MRI performed on this body part/area? **Yes** / **No** **When** and **What** doctor sent you for them?
____

5. List activities or positions that make the pain worse in this area:
____
____

6. Pain scale: (circle) (none/no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (very severe/get me to the "ER"!)

7. Pain description:(circle all that apply) **sharp dull achy tingle numb throbbing shooting stabbing burning radiating**

(Other/s please list or describe)____

8. Have you ever received physical therapy care? **Yes** / **No** If yes, **When** and **What** problem/body area was treated?
____

9. Are you currently receiving any form of home health services? **Yes** / **No** For **What**? ________________________

10. Job title/description: ____ Is this current injury work related? **Yes** / **No**

CHECK ANY OF THE SYMPTOMS THAT YOU CURRENTLY HAVE:

O Neck Pain	O Asthma	O Joint Swelling	O Chest Pains
O Neck Stiff	O Allergies	O Diabetes	O Shortness of Breath
O Pain in Hands or Arms	O Nervousness	O Menstrual Cramps	O Dizziness
O Irritability	O Stomach Upset	O Loss of Balance	O Pain between Shoulders
O Loss of Memory	O Constipation	O High Blood Pressure	O Shoulder Pain
O Depression	O Diarrhea	O Heart Attack	O Low Back Pain
O Sleeping Problems	O Loss of Smell or Taste	O Stroke	O Pain in Legs or Feet
O Pain Worse at Night	O Fatigue	O Headaches	O Fever
O Tension	O Numbness in Legs or Feet	O Lights Bother Eyes	O Weight Loss
O Sinus Pain	O Cancer or Tumors	O Numbness in Hands or Arms	

O Other (optional) ____

HEALTH HISTORY:

A. List any other previous major past medical history or surgeries: (and dates)
____
____

B. Current Rx Medications: (if you have a list please allow us to photocopy it)
____
____

C. Do you have a pacemaker or defibrillator device implant? **Yes** / **No** **When?**
____

D. Do you have any metal implants / joint replacements? **Yes** / **No** **Where?**
____

Patient Name_________________________________ ***Signature***____