MÕTUS PHYSCIAL THERAPY HEALTH HISTORY FORM

Name: _____ Date: _____

Employment (please circle):

Working full-time Working part-time Light Duty Time Loss Student Retired Unemployed

General Health Status (please circle):

Please rate your health: Excellent Good Fair Poor

Have you had any major life changes during the past year? Yes No

Health Habits:

Do you smoke? Yes No

Do you drink alcoholic beverages? Yes No If so, how many drinks on average per week? _____

Do you exercise beyond daily activities and chores? Yes No Days per week____ Hours per day_____

Current Conditions/Major Complaints:

Describe the problem you are here for today _____

When did the problem begin? _____ Describe the causative factors _____

Have you ever had this problem before? Yes No If so, how was it treated? _____

How are you treating this problem now? _____

What make the problem worse? _____

What makes the problem better? _____

What are your goals for physical therapy? _____

Functional Status/Activity Level:

Please circle any activities which are limited: Bed Mobility Transfers Walking Stair Climbing Self care Household Chores/Yard Work Driving Work School Sports or Exercise Other:_____

Medical History:

Please circle if you have ever had any of the following: Arthritis Cancer Osteoporosis Blood Disorders Circulation Problems Cardiac Problems High Blood Pressure Lung Problems Depression Diabetes Low Blood Sugar Head Injury Multiple Sclerosis Muscular Dystrophy Parkinson's Disease Seizures Asthma Thyroid Problems Tuberculosis Hepatitis Other Infectious Disease Kidney Disease Ulcers Fractures Stroke Other:_____

Now or within the past year, have you had any of the following symptoms: Chest Pain Heart Palpations Dizziness Shortness of Breath Weakness in Extremities Loss of Balance Joint Pain or Swelling Night Pain Headaches Difficulty Walking Difficulty Sleeping Loss of Appetite Nausea/Vomiting Weight Gain/Loss Fever/Sweats Hearing Problem Vision Problems Other: _____

Men: Have you been diagnosed with prostate disease? Yes No

Women: Are you pregnant or think you might be pregnant? Yes No

Medications: Please list any medications you are taking: _____

_____

Please list any nonprescription medication or supplements you are taking:_____

_____