REHABILITY
Care...to move

Your Health Status

Name: ______________________ **Date of Birth:** ____________ **Age:** ______ **Date:** ______

Why do you need physical therapy today? ____

List any previous treatment(s) you have had for this condition: ______________________________

Please check any of the following health conditions that you currently or previously experienced.

☐ Heart disease or chest pain
☐ Blood pressure issues
☐ Breathing problems (asthma, emphysema, etc.)
☐ Circulation problems (varicose veins, phlebitis, etc.)
☐ Blood disease (anemia, AIDS, etc.)
☐ Liver problems (hepatitis, jaundice, etc.)
☐ Cancer
☐ Diabetes
☐ Osteoporosis
☐ Arthritis
☐ Stroke/ Head injury
☐ Headaches
☐ Fainting/ Dizzy spells
☐ Seizures
☐ Hernia
☐ Unexplained weight loss
☐ Pregnant/ Possibly pregnant
☐ Previous surgery____________
☐ Other____________________

List all medications you are currently taking. ____

Are you currently engaging in any form of exercise? Yes/No **If yes, list activity and how often.** ____________________

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What is your job? ____

Describe the types of activities involved in your job/ normal day (e.g., heavy lifting, stair climbing, walking, sitting at a desk, bending). ____

What do you hope to accomplish with physical therapy? ______________________________________

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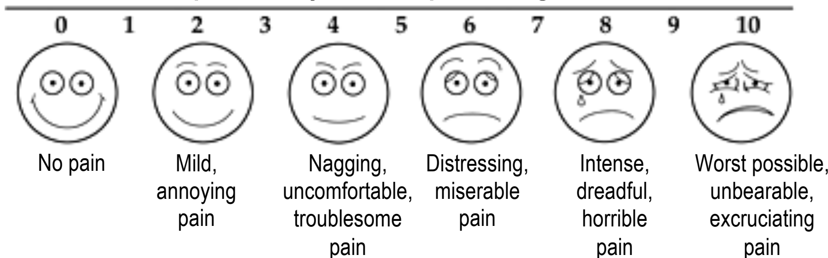
Circle the pain level you are experiencing TODAY



Pain frequency:

___ Constant
___ Comes and goes at regular times
___ Happens once in a while

Relationship of pain to sleep:

___ Wakes from sleep
___ Prevents sleep
___ Better after sleep

Put X's on the diagram where you are currently feeling pain: