Health Link
PHYSICAL THERAPY

To provide you with more effective physical therapy care, certain information about your medical history is needed. The few minutes you spend completing this will be an important contribution to your overall care. Don't worry if you are not sure of the answer to any part or question. You'll have a chance to go over it with your PT. This information will be held in the strictest confidence according to the current standards for medical records.

Client History

Name:_____ Date ____/____/____

Address:_____

Date of Birth: ____/____/____ Age_____Occupation: _____ email:

Phone: (____) _____ (____) ___ (____) _____
home work cellular

Emergency Contact: _____ phone:_____ Relationship

Family Doctor/ Health Care Practitioner_____ When is your next visit?_____

Briefly describe what happened? When did this condition start?

This problem is the result of:
[ ] auto accident
[ ] work injury
[ ] sports related injury
[_] legal case
[ ] other _____

To all **FEMALE** patients:
Are you pregnant?
Yes____ No____ Maybe____

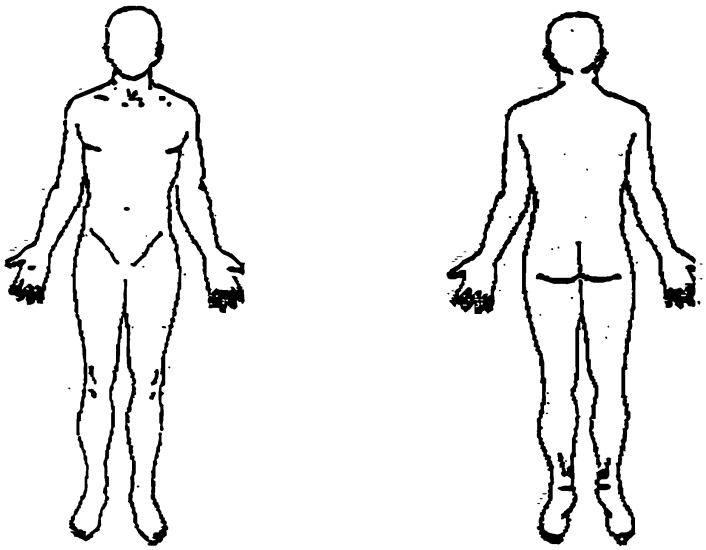
Tests:
Please check any tests that you have had for this condition:

	Results?
[ ] X-ray	_____
[ ] CT Scan	_____
[ ] MRI	_____
[ ] Myelogram	_____
[ ] EMG/NCS	_____
[ ] Ultrasound	_____
[ ] Mammogram	_____
[ ] Other	_____

Prior Treatment:
Who else have you seen for this condition?

[ ] Chiropractor
[ ] Medical Specialist
[ ] Massage or body work therapist
[ ] Acupuncturist
[ ] Counselor/Psychologist
[ ] Physical therapist, Occupational therapist
[ ] Other_____

Please draw on these figures where you are having problems/symptoms:



Are you in pain? Or do you have symptoms?

no pain **Unbearable**

0 1 2 3 4 5 6 7 8 9 10

What is the worst it has been in the last 1-4 weeks? _____
What is the best it has been in the last 1-4 weeks? _____

What do your symptoms feel like?

What makes your symptoms feel better?

What makes you feel worse?

What can you **NOT** do or have difficulty doing because of this condition?

What medications do you take? (over the counter and prescription), herbs, supplements or provide a copy for your chart:

Do you sleep well since this condition started?	yes	no
Are you under a lot of stress?	yes	no
Do you eat nutritionally balanced foods?	yes	no
Is your life balanced in all that you do? Recreation, Spiritual, Work, Family, Physical?	yes	no
Are there things that you value or make your life whole that you are unable to do right now?	yes	no

Life Habits

Circle and list what applies to you:

Play sports _____

Exercise regularly (30 min 3x/wk) _____

Hobbies _____

Computer use (hours) _____

Take caffeine drinks (>6 cups) _____

Drink 2 or more alcoholic drinks/ day _____

Use aspirin/ibuprofen _____

Smoke cigarettes/ Vape _____ pack(s)/day _____cigs/day _____ cartridges/day

Chew tobacco yes no

Drive vehicle over 25000 mi./yr. yes no

Health History

Have you been **hospitalized** or had any **operations**? (Exclude normal pregnancies) Please list most recent ones first. Have you had more than 4 hospitalizations? ____yes ____no

	Year	Operation/Illness	Name of Hospital	City? State
1.				
2.				
3.				
4.				

What do you want to accomplish through this physical therapy visit?

_____

Review of Systems

Do you have now or have had in the past, any of the following:

	Now	Past		Now	Past
1. Frequent headaches			29. Eczema/ Hives		
2. Eye problems			30. Blood clotting problems		
3. Hearing loss			31. Polio / Post polio		
4. Nose or throat problems			32. Epilepsy (seizure disorder)		
5. Asthma/ Allergies			33. Head injury		
6. Emphysema			34. Tremors or trembling		
7. Pneumonia			35. Nervous breakdown		
8. Tuberculosis			36. Depression		
9. Bronchitis			37. Tension/ Anxiety		
10. High blood pressure			38. Worry a lot		
11. Rheumatic fever			39. Difficulty relaxing		
12. Chest pain			40. Sleep difficulty		
13. Heart murmur			41. Fatigue/ Exhaustion		
14. Shortness of breath			42. Use of hard drugs		
15. Dizzy spells			43. Alcoholism /Addictions		
16. Stomach / duodenal ulcer			44. Liver disease		
17. Diverticulosis			45. Genetic disease		
18. Heartburn / Digestive Problems			46. Childhood hyperactivity		
19. Incontinence (wet your pants)			47. Thyroid disease		
20. Kidney / Bladder trouble			48. Auto immune disease		
21. Prostate trouble (men)			49. Hernia		
22. Problem with menstrual cycle (women)			50. Cancer or tumor		
23. Stiff joints			52. Stroke		
24. Osteoarthritis			53. Hepatitis A____, B_____, C_____		
25. Rheumatism/ arthritis			54. Crohns Disease or Celiac Disease		
26. Osteoporosis			55. Anemia		
27. Thirsty often (polydipsia)			56. Pancreatitis		
28. Urinate > 6x/day(polyuria)			57. Diabetes		

I understand that the above questionnaire will be used by Health Link Physical Therapy, LLC to arrive at accurate physical therapy diagnosis and treatment of my condition(s). I understand that all answers given will be held in the ***strictest confidence*** according to the current standards of medical records. My signature below certifies that the answers given are complete and true.

Your signature:_____ Date:_____