Physical Therapy at thrive, LLC

HEALTH HISTORY FORM

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DEMOGRAPHIC INFORMATION

Patient name: ..... **Age:** ..... **Date of birth:** .....

Address: ..... **City:** ..... **State:** ..... **Zip:** .....

Phone: ..... **Cell:** ..... **Email:** .....

Social Security #: ..... **Gender:** ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Divorced/separated ❍ Single (never married) ❍ Widowed

EMERGENCY CONTACT

Name: ..... **Relationship:** ..... **Phone:** .....

REFERRAL INFORMATION

Referring doctor: ..... **Primary doctor:** .....

When is your next doctor's appointment? .....

How did you hear about Thrive? ❍ Friend/family ❍ Health care provider ❍ Exercise instructor
❍ Massage therapist ❍ Location ❍ Website ❍ Other (list) .....

Were you referred to a specific therapist? ❍ Yes ❍ No **If yes, which therapist?** .....

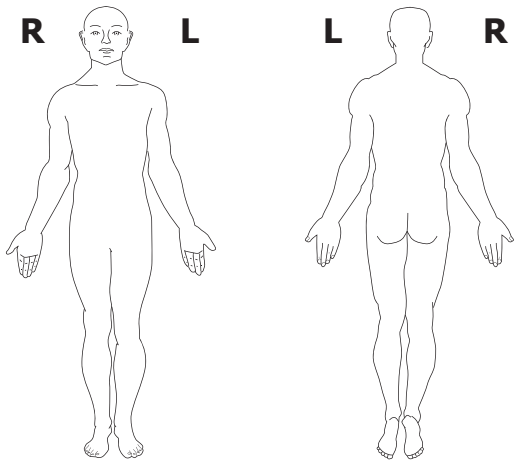
EMPLOYMENT

Occupation: ..... **Employer name:** .....

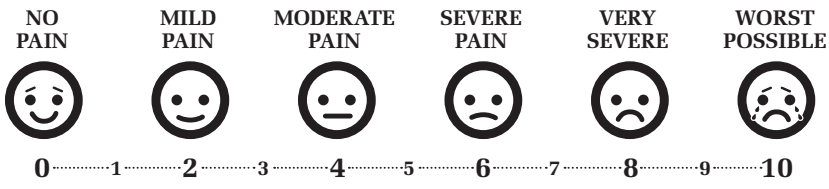
Employer phone: ..... **Employer address:** .....

AREAS NEEDING TREATMENT

Using the diagrams on the right, please mark with an "X" the areas where you are experiencing pain.



Please rate your current pain level:



GENERAL HEALTH

Please rate your present health: ❍ Excellent ❍ Good ❍ Fair ❍ Poor

Have you had any life changes in the past year? (i.e. birth, death, move, job change, marriage/separation, etc)
❍ Yes ❍ No **If yes, please describe:** .....

Are you pregnant? ❍ Yes ❍ No ❍ Not sure ❍ Not applicable

Hours of sleep you get at night, on average: ..... **Do you wake up feeling well rested?** ❍ Yes ❍ No

Do you have any cultural or religious beliefs we should be aware of? ❍ Yes ❍ No

If yes, please list/describe: .....

Have you ever been diagnosed as having any of the following conditions? Please check "yes"or "no".

Lung cancer	❍ Yes ❍ No	Emphysema	❍ Yes ❍ No
Breast cancer	❍ Yes ❍ No	Chemical dependency (i.e. alcoholism)	❍ Yes ❍ No
Prostate cancer	❍ Yes ❍ No	Depression	❍ Yes ❍ No
Colon cancer	❍ Yes ❍ No	Anxiety	❍ Yes ❍ No
Skin cancer	❍ Yes ❍ No	Memory loss or changes	❍ Yes ❍ No
Bone cancer	❍ Yes ❍ No	Nervous, mental or behavioral history (bipolar, schizophrenia, attempted suicide, psychotic disorder)	❍ Yes ❍ No
Leukemia cancer	❍ Yes ❍ No		
Lymphoma cancer	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Other cancer (please list):		Hypothyroid (low)	❍ Yes ❍ No
		Hyperthyroid (high)	❍ Yes ❍ No
Chronic urinary tract/bladder infection (3 episodes+ during past 12 months)	❍ Yes ❍ No	Diabetes: diagnosed before age 18 diagnosed after age 18	❍ Yes ❍ No ❍ Yes ❍ No
Pneumonia	❍ Yes ❍ No	Multiple sclerosis	❍ Yes ❍ No
Bone or joint infection	❍ Yes ❍ No	Rheumatoid arthritis	❍ Yes ❍ No
Pelvic inflammatory disease	❍ Yes ❍ No	Degenerative osteoarthritis (wear and tear arthritis)	❍ Yes ❍ No
Kidney infection	❍ Yes ❍ No		
Other infection (please list):		Gout	❍ Yes ❍ No
		Ankylosing spondylitis	❍ Yes ❍ No
Heart attack	❍ Yes ❍ No	Hepatitis	❍ Yes ❍ No
Heart valve problems	❍ Yes ❍ No	Stomach/duodenal ulcers	❍ Yes ❍ No
Congestive heart failure	❍ Yes ❍ No	Acid reflux (GERD)	❍ Yes ❍ No
Heart rhythm problems or pacemaker	❍ Yes ❍ No	Diverticulitis	❍ Yes ❍ No
Deep venous thrombosis (blood clots in legs)	❍ Yes ❍ No	Epilepsy/seizures	❍ Yes ❍ No
Arterial blockage of the legs	❍ Yes ❍ No	Headaches (more than 1 per week)	❍ Yes ❍ No
High blood pressure	❍ Yes ❍ No	Endometriosis	❍ Yes ❍ No
High cholesterol	❍ Yes ❍ No	Urinary incontinence	❍ Yes ❍ No
Vascular disease (coronary artery disease, peripheral vascular disease)	❍ Yes ❍ No	Osteoporosis or osteopenia	❍ Yes ❍ No
		Seasonal allergies	❍ Yes ❍ No
Stroke (including transient ischemic attacks or mini strokes)	❍ Yes ❍ No	Other illnesses diagnosed by a physician (please list):	
Anemia/low blood levels	❍ Yes ❍ No	Injuries related to tendons/muscles, joints, bones (please list):	
Asthma	❍ Yes ❍ No		

Have you ever had any of the following surgeries? Please check "yes"or "no".

Cesarian section	❍ Yes ❍ No	Carpal tunnel surgery	❍ Yes ❍ No
Hysterectomy	❍ Yes ❍ No	Hernia repair	❍ Yes ❍ No
Female gynecologic surgeries (please list):		Tonsillectomy	❍ Yes ❍ No
		Eye surgery	❍ Yes ❍ No
Breast procedures	❍ Yes ❍ No	Oral surgery	❍ Yes ❍ No
Heart surgery (bypass)	❍ Yes ❍ No	Bone/joint/orthopedic surgeries (please list):	
Prostate surgery	❍ Yes ❍ No		
Appendectomy	❍ Yes ❍ No	Other surgeries (please list):	
Gall bladder surgery	❍ Yes ❍ No		
Peripheral vascular procedures	❍ Yes ❍ No		

Do you take any of the following medications NOT prescribed by a physician? Please check "yes" or "no".

Anti-inflammatories (i.e. Advil, Motrin, Aleve, Ibuprofen)	❍ Yes ❍ No	Decongestants/antihistamines	❍ Yes ❍ No
Aspirin	❍ Yes ❍ No	Tagamet, Zantac, Pepsid	❍ Yes ❍ No
Tylenol/Acetaminophen	❍ Yes ❍ No	Herbal medications	❍ Yes ❍ No
Antacids (i.e. Tums, Rolaids)	❍ Yes ❍ No	Mineral supplements (i.e. iron, potassium)	❍ Yes ❍ No
Laxatives	❍ Yes ❍ No	Other medications (please list):	

Do you take any of the following PRESCRIBED medications? Please check "yes"or "no".

Aspirin	❍ Yes ❍ No	Heart medications (other than for high blood pressure)	❍ Yes ❍ No
Anti-inflammatories (i.e. Motrin, Naprosyn, Relafen, Diclofenac)	❍ Yes ❍ No	Antibiotics	❍ Yes ❍ No
Tylenol/acetaminophen	❍ Yes ❍ No	Thyroid medication	❍ Yes ❍ No
Muscle relaxers (i.e. Valium, Flexeril)	❍ Yes ❍ No	Asthma medication	❍ Yes ❍ No
Prescribed pain relievers (i.e. Darvocet, Darvon, Percocet, Vicodin, Tylenol w/ codeine)	❍ Yes ❍ No	Antidepressant medication	❍ Yes ❍ No
		Insulin	❍ Yes ❍ No
Birth control pills	❍ Yes ❍ No	Oral hypoglycemics (i.e. Orinase, Glucophage)	❍ Yes ❍ No
Hormone replacement therapy (estrogens/progesterones)	❍ Yes ❍ No	Seizure medication	❍ Yes ❍ No
High blood pressure medications	❍ Yes ❍ No	Neurontin	❍ Yes ❍ No
Cholesterol lowering medications (i.e. Zocor, Lipitor, Mevacor)	❍ Yes ❍ No	Biphosphonates/bone strengtheners (i.e. Fosamax, Didronel)	❍ Yes ❍ No
Water pills (diuretics) for reasons other than high blood pressure	❍ Yes ❍ No	Decongestants/antihistamines for sinus or allergy problems	❍ Yes ❍ No
Stomach ulcer medications	❍ Yes ❍ No	Other medications (please list):	

Indicate whether any family member has had the following, and date of onset, if known:

Heart Disease	❍ Yes ❍ No	Date:
Hypertension	❍ Yes ❍ No	Date:
Stroke	❍ Yes ❍ No	Date:
Diabetes	❍ Yes ❍ No	Date:
Cancer	❍ Yes ❍ No	Date:
Psychological	❍ Yes ❍ No	Date:
Arthritis	❍ Yes ❍ No	Date:
Osteoporosis	❍ Yes ❍ No	Date:
Auto-immune problems	❍ Yes ❍ No	Date:

How many cups of caffeinated beverage do you drink each day?		
Number of days per week you drink alcohol?		Number of drinks per day?
Do you currently use tobacco?	❍ Yes ❍ No	If yes, how many cigarettes/cigars per day?
Did you smoke in the past?	❍ Yes ❍ No	If yes, when did you quit?
Do you exercise beyond daily activities and chores?	❍ Yes ❍ No	If yes, number of days per week?

Please list the most common ways you exercise (include activities in all four seasons):

Patient or legal representative signature ..... **Date** .....