Current Health Condition

Name_____**Date**_____

Birth Date_____ **Age**_____ **Height**_____ **Weight**_____

Gender_____ **Hand** **Dominance:** ❑ Right ❑ Left

Occupation_____

Reason for seeking physical therapy_____

What are your symptoms?_____

Location of symptoms?_____

When did your symptoms begin?_____

Are your symptoms changing?_____

Are your symptoms: ❑ Constant ❑ Intermittent ❑ Infrequent ❑ Variable

Are your symptoms worse at a certain time of day? ❑ Yes ❑ No

If yes, worse at ❑ Night ❑ Morning ❑Other_____

Does this condition affect your sleep and if so how? _____

Have you had testing or imaging? ❑ Yes ❑ No **If yes, what was done?**_____

Have you had this problem before? ❑Yes ❑ No **If so, when?**_____

Have you had a history of trauma? ❑ Yes ❑ No **If yes,**

explain_____

Was a surgery performed? If so, when? _____

Have you had physical therapy or other treatments for this condition? ❑ Yes ❑ No

If yes, please describe_____

What activities make your pain/symptoms better?_____

What activities make your pain/symptoms worse?_____

How has quality of life been impacted?_____

How would you rate your current level of stress? ❑ Low ❑ Medium ❑ High

How do you manage stress?_____

Previous Surgeries (*please list all and date*)

1._____

2._____

3._____

Previous Injuries/Orthopedic Problems/Motor Vehicle Collisions (*include date*)

1._____

2._____

3._____

Current Medications and/or Supplements and reason for taking

1._____

2._____

3._____

What hobbies, sports, fitness &/or recreational activities do you do regularly?

_____

_____

What goals do you have for therapy?

_____

_____

Signature_____ ***Date***_____

Client Name:_____

General Medical/Health History

How would you classify your general health? ❑ Good ❑ Fair ❑ Poor

In terms of your general health, please check *ALL* that apply

☐ Alcohol/Drug Problems
☐ Allergies
☐ Anemia
☐ Asthma/Breathing Difficulties
☐ Cancer
Type:_____
☐ Change in Bowel/Bladder Function
☐ Chest Pain/Angina
☐ Concussions
☐ Depression
☐ Diabetes I or II
☐ Fibromyalgia
☐ Heart Attack
☐ Heart Disease
☐ Heart Palpitations
☐ Hepatitis
☐ Hernia
☐ High/Low Blood Pressure
☐ HIV
☐ Hypoglycemia
☐ Intolerance to Cold/Heat
☐ Jaw/Dental Issues
*Explain:*_____
☐ Kidney Problems
☐ Liver/Gallbladder Problems
☐ Metal Implants
☐ Multiple sclerosis
☐ Night pain
☐ Numbness/Tingling
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Pain with Cough/Sneeze
☐ Physical Abnormalities
☐ Polio
☐ Recent Dizziness
☐ Recent Headaches
☐ Recent Fever
☐ Recent Fractures
☐ Recent Nausea/vomiting
☐ Recent Unexplained Fatigue
☐ Recent Vision Changes
☐ Rheumatoid Arthritis
☐ Ringing in the ears
☐ Seizures/Epilepsy
☐ Skin Abnormalities
☐ Smoking History
☐ Stroke/TIA
☐ Surgeries
☐ Unexplained Weight Loss/Gain
☐ Vertigo/Vestibular Disorders
☐ Vision Changes
☐ Other_____

Pelvic Medical/Health History

In terms of your pelvic health, please check ALL that apply (complete only if applicable

☐ Coccyx Pain
☐ Constipation
☐ Currently Pregnant
☐ Diarrhea
☐ Endometriosis
☐ Erectile Dysfunction
☐ Fecal or Gas Incontinence
☐ IBS
☐ Painful Ejaculation
☐ Painful Periods
☐ Pelvic Pain
☐ Physical or Sexual Abuse
☐ Prostate Disorders
☐ Sexual Dysfunction
☐ Sexually Transmitted Disease
☐ Shy Bladder
☐ Urine Leakage
☐ Vaginal Dryness

Menopause? ☐ Yes ☐ No **If yes, date:**_____

Date of Last Pelvic Exam:_____

Number of Pregnancies:_____ **Number of Child Births:**_____

Number of C-Sections:_____ **Number of Vaginal Deliveries:**_____