washougal sport&spine
PHYSICAL THERAPY

PATIENT HEALTH HISTORY FORM

NAME_____ **BODY PART**_____ **DATE**_____

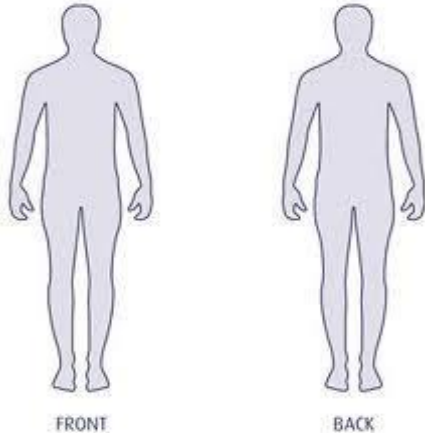
Occupation_____ Interests/Hobbies_____

Next scheduled Dr. Appointment: Date_____ Physician_____

Questions About Your Condition:

When did your condition start? Give specific date of injury or onset of pain: _____

Do you have PAIN? If so DRAW on the BODY CHART where your pain is located →



____SHARP____BURNING____ACHING____TINGLING____NUMBNESS____OTHER

Does pain radiate to arms or legs? **YES** **NO** Does the pain keep you up at night? **YES** **NO**

Rate your PAIN on a 0 to 10 scale: 0=none, 10=severe (circle one)

0 1 2 3 4 5 6 7 8 9 10

Activity Level: ____**LOW**____**MEDIUM**____**HIGH**

Recent weight loss or gain? **YES** **NO** How much?_____

Have you fallen in the past year?_____

Are you currently taking any medications? **YES** **NO** Please list:_____

Did you have surgery? **YES** **NO** When?_____ Where?_____ Surgery Type_____

Did you have any of the following tests? **YES** **NO** XRAY___ MRI___ CT Scan___ EMG___ OTHER_____

Have you been treated here or by another physical therapist before? **YES** **NO** Same Condition? **YES** **NO**

Where?_____ When?_____ Who referred you to WSS?_____

Any other condition we should be aware of?_____

Are you sensitive to HEAT/ICE **YES** **NO** Are you Pregnant? **YES** **NO** Were you in a Motor Vehicle Accident? **YES** **NO**

Do you now or have had any of the following? (check all that applies)

___Heart Attack ___Diabetes ___Allergies ___High Blood Pressure ___Headaches

___Pacemaker ___Kidney Problems ___Cancer ___Seizures ___Hernia ___Nervous Disorders

___Stroke ___Dizziness ___Asthma/Shortness of Breath ___Previous Surgery ___Thyroid Problems

If **yes** to **any** of the above, please give details and approximate dates._____

_____

All statements above are true to the best of my knowledge_____

PATIENT SIGNATURE AND DATE

For clinic use only: ***Height***_____ ***Weight***_____ ***BP***_____***HR***_____