washougal sport & spine
PHYSICAL THERAPY

PATIENT HEALTH HISTORY FORM

NAME____**BODY PART**___________________**DATE**____________________

Occupation____Interest/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? ____

Did you have surgery? **YES** **NO** When? _____________Where?______________________ Surgery Type_________________

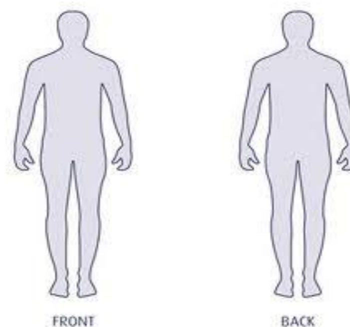
Did you have any of the following tests? **YES** **NO** ____XRAY____MRI____CT Scan____EMG____OTHER______________________

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

Where?______________________ When?________________ Who referred you to WSS?____________________________

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

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



What does your pain feel like? (check all that apply)

____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 1 2 3 4 5 6 7 8 9 10 (circle one)

0=none, 10=severe

Activity Level: ____**LOW**____**MEDIUM**____**HIGH**   Recent weight loss or gain? **YES** **NO** How much?__________________

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 what applies)

___Heart Attack ___Diabetes ___Allergies ___High Blood Pressure ___Heart Attack ___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 give approximate dates. ____________________________________

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All statements above are true to the best of my knowledge____

PATIENT SIGNATURE AND DATE