Priority Physical Therapy, Inc.
Health Is Our Priority; Make It Yours.

CONFIDENTIAL HEALTH HISTORY FORM

Thank you for taking the time to share this important information about yourself!

Today's date: _____/_____/_____ Reason for this visit? _____
Date symptoms/problem started: _____/_____/_____
Cause of symptoms? □ Injury □ Unknown
□ Work Related? Yes/No Has a claim been filed with employer? Yes/No
□ Motor vehicle accident Lawsuit Pending? Yes/No
□ Other _____
Are you experiencing any pain? □ No □ Yes If yes, please respond below:

Where is the pain located? _____

How intense is the pain?

At best: None_____Severe/emergency
0 1 2 3 4 5 6 7 8 9 10
At worst: None_____Severe/emergency
0 1 2 3 4 5 6 7 8 9 10
Now: None_____Severe/emergency
0 1 2 3 4 5 6 7 8 9 10

How long have you had the pain? _____Years _____Months _____Weeks _____Days

How often do you experience the symptoms? □ Constantly □ Intermittently

What does the pain feel like? _____

What is an acceptable level of pain? None_____Severe/emergency
0 1 2 3 4 5 6 7 8 9 10

Do your symptoms interfere with any of the following? □ Work □ Sleep

How are your symptoms changing? □ Not changing □ Getting better □ Getting worse

Falls Screen: How many times have you fallen in the past year? 0 1 2 3 4 5 5+

If you have fallen in the past year, did any of these falls result in injury? N/A Yes No

Have any tests been performed related to the **current symptoms**?

Type of test	Date of test	Results
□ MRI	_____/_____/_____	_____
□ X-ray	_____/_____/_____	_____
□ Bone scan	_____/_____/_____	_____
□ CT scan	_____/_____/_____	_____
□ EMG	_____/_____/_____	_____
□ _____	_____/_____/_____	_____
□ _____	_____/_____/_____	_____

Do you have any of the following habits?

Smoking:	□ No	□ Yes	Packs/day _____	For how long? _____
Alcohol:	□ No	□ Yes	Drinks/week _____	For how long? _____
Caffeine:	□ No	□ Yes	Amount/day _____	For how long? _____
High stress:	□ No	□ Yes	Reason _____	

Please provide a list of all prescription and over-the-counter medications, vitamins, herbals, minerals, and dietary supplements: (If additional space is needed, please request another form.) □ None

Medication	Dosage

Do you have any allergies? □ No known allergies □ Yes If yes, explain:

List allergy	Type of reaction

Patient height: _____'_____" Patient weight: _____lbs.

Place a check next to the appropriate condition if you have been diagnosed with or experienced any of the following: (if you check any box, please provide detail below)

□ Anemia	□ Arthritis (osteo/RA)	□ Back Problems
□ Breathing problems (ex. asthma, COPD, emphysema)		□ Blood in urine
□ Broken bones/fractures	□ Cancer	□ C-section
□ Circulation problems	□ Chest pain	□ Chronic fatigue
□ Depression	□ Diabetes	□ Dizziness
□ Earache	□ Epilepsy	□ Fainting
□ Fibromyalgia	□ Gall bladder problems	□ GERD (reflux/heartburn)
□ Headaches/migraines	□ Head injury	□ Hearing problems
□ Heart problems/CHF	□ Hernia	□ High/low blood pressure
□ Hot flashes	□ Irregular heart beat	□ Joint/muscle pain
□ Joint replacement(s)	□ Kidney disease	□ Loss of bladder/bowel control
□ Liver disease/jaundice/hepatitis	□ Mental health issues	□ Multiple Sclerosis
□ Neck problems	□ Night sweats	□ Numbness/tingling
□ Osteoporosis	□ Pacemaker	□ Pinched nerve
□ Pelvic pain	□ Pregnancy	□ Ringing in ears
□ Scoliosis/spinal curvature	□ Stroke/TIA	□ Swelling
□ Thyroid disease	□ Tumors/growth/lumps	□ Ulcers
□ Urinary/bowel frequency	□ Urinary/bowel urgency	□ Urinary tract infections
□ Vision problems	□ Weakness	□ Weight loss/gain
□ Prostate problems – Radioactive seeds implanted? Y/N		

If you checked any of the previous conditions, please provide detail below:
(If additional space is needed, please request another form.)

Condition	When	Treatment received	Ongoing problems?

Please list all surgeries you have had: (If additional space is needed, please request another form.)

Surgery	Date of surgery	Hospitalization dates

Patient/Guardian Signature:_____Date:_____
This health history form has been reviewed and edited by: _____Date:_____