RIVER CITY PHYSICAL THERAPY

HISTORY OF HEALTH

Name:_____ Today's date:_____/_____/_____

Date of Birth:_____/_____/_____ Physician: _____

Thank you for taking the time to provide us with the following information to assist in evaluation of your condition.

Medication

Please list any medication you are taking for this conditon: (including over the counter)

_____

_____

_____

Please list all other medication you are taking:

_____

_____

_____

_____

General questions

How would you rate your general health?

□ Excellent □ Good □ Average
□ Fair □ Poor

Do you smoke?

□ Yes, I smoke_____/day
□ No

What is your stress level?

□ Low □ Medium □ High

Do you exercise?

□ No
□ Yes, _____x/week
exercise type:

_____

What is your living situation?

□ live alone □ live with family/others

What is your occupation?

_____

What hobbies, social activities, or recreational activites do you enjoy?

_____

_____

_____

Past Medical History

Do you currently have, or have you ever had any of the following? (please check all that apply)

□ Cancer (type)_____ _____
□ Depression
□ Kidney problems □ Lung problems
□ Stroke □ Heart problems
□ Thyroid problems □ Blood problems
□ Diabetes □ Epilepsy / seizures
□ Multiple Sclerosis □ Allergies
□ Arthritis □ Rheumatoid Arthritis
□ Head injury □ Osteoporosis
□ Stomach problems □ Broken bones
□ Parkinson's □ Circulation problems
□ Infectios diseases (I.e. Hepatitis, Tuberculosis, etc.)

Please list past surgeries and approximate date.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History

Has anyone in your immediate family (parents, sibblings) been treated for any of the following:

□ Diabetes □ Cancer
□ Arthritis □ Heart disease
□ High Blood pressure □ Osteoporosis
□ Stroke □ Psychological condition
□ Other_____

Is there anything else we should know to assist you in the best possible manner?

_____

_____

_____