

PATIENT HEALTH INFORMATION

Name _____ Signature _____

Date ____/____/20____ Height _____ Weight _____

MARK PAINFUL AREA/S WITH AN X

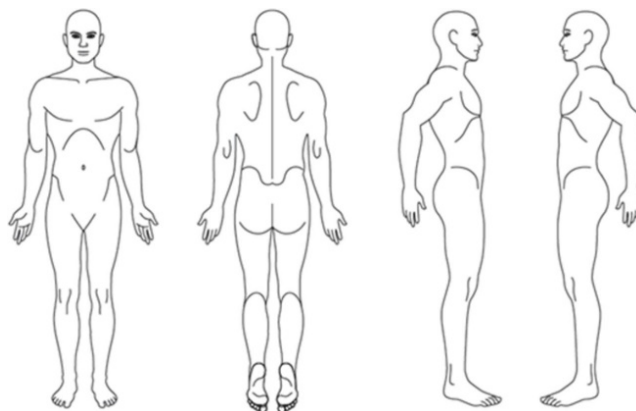
1. Primary current complaint or problem we are seeing you for today: _____

2. Date when problem/injury began: _____

3. Briefly describe how injury/problem occurred: _____

4. Did you have a recent X-Ray and/or MRI performed on this body part/area? **Yes / No** Date ____/____/20____

Requesting physician: _____



5. List activities or positions that make the pain worse in this area: _____

6. Average pain over the past 24 hours: (none/no pain) **0 1 2 3 4 5 6 7 8 9 10** (very severe)

7. Pain description (check all that apply): ☐ sharp ☐ dull ☐ achy ☐ tingling ☐ numb ☐ throbbing ☐ shooting
☐ stabbing ☐ burning ☐ radiating

Other (please describe): _____

8. Have you ever received physical therapy care? **Yes / No** If yes, **When** and **What** problem/body area was treated? _____

9. Are you currently receiving any form of home health services? **Yes / No** For What? _____

10. Job title/description: _____ Is your current injury work related? **Yes / No**

CHECK ANY SYMPTOMS/CONDITIONS YOU ARE **CURRENTLY** EXPERIENCING:

- | | | | |
|--|--|--|---|
| ☐ Neck Pain | ☐ Asthma | ☐ Joint Swelling | ☐ Chest Pains |
| ☐ Neck Stiffness | ☐ Allergies | ☐ Diabetes | ☐ Shortness of Breath |
| ☐ Pain in Hands or Arms | ☐ Nervousness | ☐ Menstrual Cramps | ☐ Dizziness |
| ☐ Irritability | ☐ Stomach Upset | ☐ Loss of Balance | ☐ Pain between Shoulders |
| ☐ Loss of Memory | ☐ Constipation | ☐ High Blood Pressure | ☐ Shoulder Pain |
| ☐ Depression | ☐ Diarrhea | ☐ Heart Attack | ☐ Low Back Pain |
| ☐ Sleeping Problems | ☐ Loss of Smell or Taste | ☐ Stroke | ☐ Pain in Legs or Feet |
| ☐ Pain Worse at Night | ☐ Fatigue | ☐ Headaches | ☐ Fever |
| ☐ Tension | ☐ Numbness in Legs or Feet | ☐ Lights Bother Eyes | ☐ Weight Loss |
| ☐ Sinus Pain | ☐ Numbness in Hands or Arms | ☐ Cancer or Tumors | |
| ☐ Other _____ | | | |



PATIENT HEALTH INFORMATION

HEALTH HISTORY

A. List any other previous major medical history or surgeries with dates:

B. List any current medications, or provide a separate attachment:

C. Do you have a pacemaker or defibrillator device implant? **Yes** / **No** Date of implant: ____ / ____ / ____

D. List any metal implants / joint replacements? _____
