Patient Health History Form

Today's Date: _____

Name _____ Date of Birth _____ Age _____
Address: _____
Phone: _____
Email: _____
Emergency Contact: Name _____
Relationship _____ and Phone _____
Referring Physician _____ Primary Physician _____
Insurance: _____ Do you have Medicare at all? _____

Current Chief Complaint or Functional Limitation:
_____
_____

When this problem begin? _____
Initiating cause of problem or injury? _____

Interventions for this problem thus far? (any therapy, surgery, massage, etc?)
_____
_____

Experience from previous interventions? (what helped, did anything make worse, no change?)
_____
_____

What physical activity do you do regularly? _____
_____
_____

Daily Activities that you CANNOT perform because of pain or functional limitation from this problem: _____
_____

What is (are) your **GOAL(s)** for therapy? What would you like for me to be able to help you with?

_____

_____

Current meds, vitamins and/or supplements you are taking, or are prescribed to take:

Name of Product	Prescription or OTC	Dosage Amount and frequency	Reason for medi-cation	complaint?

ALLERGIES TO MEDICATIONS

Name of medication or ingredient	Type of Reaction?

Past Medical History (diagnoses, and approximate date diagnosed)

Diagnosis	Date Diagnosed (or approximate)

Notes: _____

_____

Past Surgical History

Surgery, (including Right or Left, if appro-priate)	Date	Surgeon/Location	Any complications?

Any internal electrical devices? (Pacemaker, Brain/Spinal Stimulator, Diabetic Pump?) _____
Notes: _____

For those with Scoliosis, Kyphosis, Scheurmann's, or hypokyphosis:

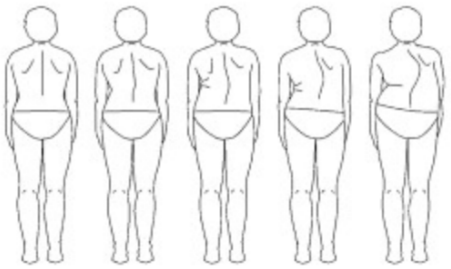
Current Cobb angles and location if known (example thoracic, lumbar) _____
_____
Thoracic Kyphosis angle (side view), if known _____
Lumbar Lordosis angle (side view), if known _____
What bothers you most about your posture? _____
_____

Risser score, if known _____
Year or age of start of menstruation if applicable: _____

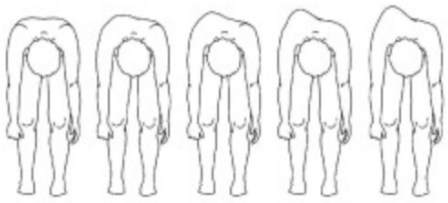
History of Bracing:

Date (from when to when?)	Type or name of brace	#hours/day told to wear	Level of compliance (Always, Most, Some, or Not a Chance)

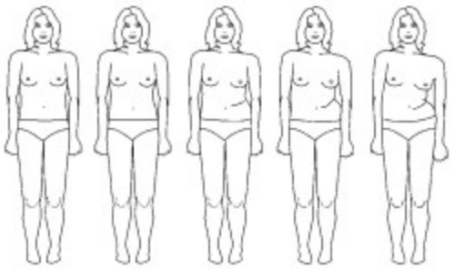
Please circle the images below as to how you feel it most accurately resembles your current



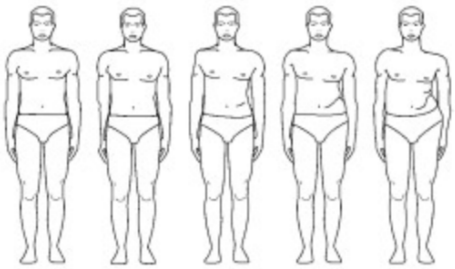
SET 1



SET 2



SET 3 (females)



SET 3 (males)

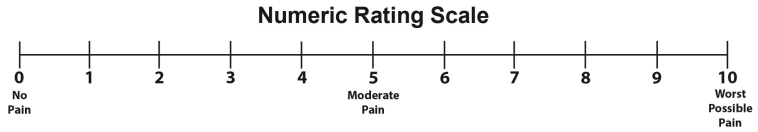
physical presentation. For set 3, you only need to circle respective to your gender.

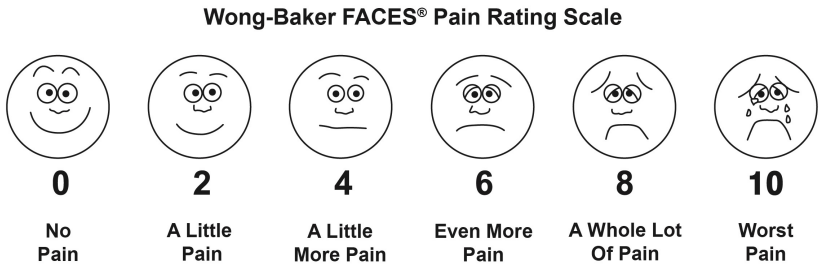
For ALL Clients: Pain Section

- Do you have any pain associated with the current problem ? _____
- Does the pain radiate or refer to other areas? _____ If so, where and when? _____

_____

- Please mark on the diagram location and type of pain.
- Does pain wake you in the middle of the night? _____
- Does pain limit your ability to get comfortable in bed? (different than above question) _____
- What makes the pain better? _____
- What makes the pain worse? _____





- How would you rate the pain on a scale of 1-10? (You can include a range - best to worst)

- What is your goal for pain relief considering the above scale?

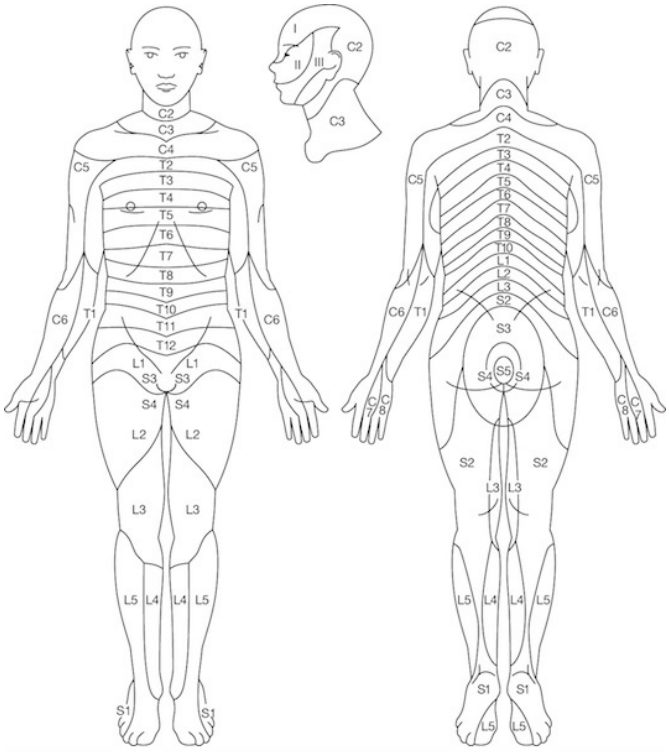
  _____

Please denote pain or abnormal sensation on the image to the right.

x = pain
☆ = numbness
T = tingling/pins & needles

Please circle pain description:

stabbing
throbbing
dull
achy
sharp
shooting/radiating
pulling



Supplied by Grünenthal Ltd.

Thank you for taking the time to share this essential information!