Client History

Name:_____ (**Male** / **Female**) Date: _____.

Age: _____ Height: _____ Weight: _____ Occupation:_____.

CHIEF COMPLAINT AND PRESENT ILLNESS

Date symptoms/ injury started:_____Date of most recent doctor visit:_____.

Diagnosis from your doctor:_____. Date of next doctor recheck:_____.

What is your primary reason for attending therapy? *(circle)*

1) Pain
2) Limited motion
3) Weakness
4) Activity reduction
5) Loss of independence
6) Unable to work
7) Unable to do household tasks
8) Unable to play sports or do recreation

Are you currently off work because of this problem? (**Yes** / **No**) If yes, last day worked:

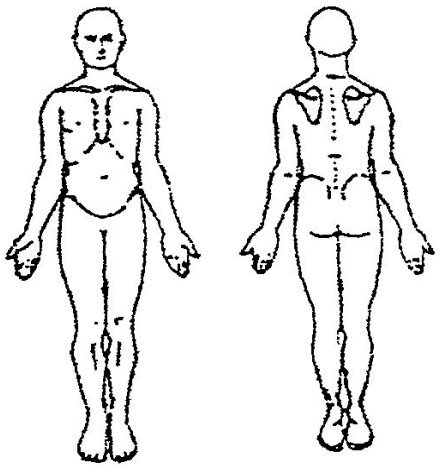
How did your symptoms start?

How would you describe your problem?

RATE your pain level: **No pain 1 2 3 4 5 6 7 8 9 10 Worst pain**

How would you DESCRIBE your pain?

__ Dull ache __ Burning __ Heavy __ Sore
__ Deep ache __ Throbbing __ Twinge __ Other *(explain)*
__ Stabbing __ Squeezing __ Cramp
__ Nagging __ Drawing __ Sharp



Using the diagram, circle the specific area of pain. If pain travels draw arrows.

Do you have any numbness/ tingling? (**Yes** / **No**)
Where?

Prior to this onset were you free of these symptoms? (**Yes** / **No**)
Explain:

What eases the pain?
What aggravates the pain?

Have you had any other treatment for this problem? (**Yes** / **No**)

If yes, what?

Did it help? (**Yes** / **No**) Do you feel you are (**getting better**, **getting worse**, or **staying the same**)?

Please list diagnostic imaging or tests and relevant findings:

Please complete opposite side

MEDICATIONS
Please list ALL PRESCRIPTION AND OVER THE COUNTER medications for this and any other condition:

Current Meds:	**Dosage**	**Frequency**	**Route**	**Reason Taking**
1				
2				
3				
4				
5				
6				

HEALTH HISTORY

__ Allergies
__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Autoimmune Disorder
__ Cancer
__ Cardiac Conditions
__ Cardiac Pacemaker
__ Chemical Dependency
__ Circulation Problems
__ Currently Pregnant
__ Depression
__ Diabetes
__ Dizzy Spells
__ Emphysema/Bronchitis
__ Fibromyalgia
__ Fractures
__ Gallbladder Problems
__ Headaches
__ Hearing Impairment
__ Hepatitis
__ High Cholesterol
__ High / Low Blood Pressure
__ HIV / AIDS
__ Incontinence
__ Kidney Problems
__ Metal Implants
__ MRSA
__ Multiple Sclerosis
__ Muscular Disease
__ Osteoporosis
__ Parkinson's
__ Rheumatoid Arthritis
__ Seizures
__ Smoking
__ Speech Problems
__ Strokes
__ Thyroid Disease
__ Tuberculosis
__ Vision Problem

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above:

Allergy to LATEX? (**Yes** / **No**)

GENERAL HEALTH
If you have been seen by any healthcare provider during the past 3 months for reasons other than what brought you here, please describe for what reason:

Please list any surgeries, hospitalizations, emergency care, or injuries. Include the approximate date and reason.
Date: **Reason:**

Have you experienced any of the following since the onset of your symptoms ? *(Check all that apply)*
__ Change in energy level __ Fever/night sweats __ Shortness of breath __ Chest pain
__ Skin/nail changes __ Bowel/bladder changes/dysfunctions __ Palpable growing mass

Please describe your current HEALTH HABITS:
Has your appetite changed in the past 3 months (**Yes** / **No**) or 2 years (**Yes** / **No**) ?
Any unexplained weight loss? (**Yes** / **No**)

How often do you take time for exercise? (**Daily** / **___ days per week** / **less than once per week**)
How do you engage in exercise?