SPRINGER
—PHYSICAL THERAPY—

Health History (Please Print) Today's Date:

Patient Name(Last, First, MI)_____Age_____

Do you have a Pacemaker?_____ Do you Smoke?_____ Are you latex sensitive?_____

Allergies:_____

Have you ever taken steroid medication for any medical conditions? _____

Have you ever taken blood thinning or anticoagulant medication for any medical conditions? _____

SURGERIES, INJURIES, AND HOSPITALIZATIONS (provide dates)

Diagnostic test(i.e X-ray, MRI, CT, Bone Scan, Blood test):_____

Treatment received so far for this injury, pain or problem:_____

Occupation, including activities that comprise your work day:_____

Are you on work restriction from your doctor? Please explain:_____

Leisure activities, including exercise:_____

WOMEN ONLY: Are you currently pregnant or think you may be pregnant? YES NO If yes, how many weeks_____

Have you RECENTLY experienced any of the following (check all that apply)?

- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Weight loss/gain
- ☐ Difficulty maintaining balance while walking
- ☐ Falls
- ☐ Numbness or tingling
- ☐ Muscle weakness
- ☐ Dizziness/lightheadedness
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Changes in bowel or bladder
- ☐ Constipation
- ☐ Diarrhea
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cough
- ☐ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Aids/HIV
- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pains/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Bone or Joint Infection
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Infection(s)
- ☐ Sexually transmitted disease
- ☐ Pelvic inflammatory disease
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Auto Immune
- ☐ Epilepsy/Seizures
- ☐ Eye problems
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis

Has anyone in your immediate family EVER been diagnosed with any of the following conditioning? (Check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Depression
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Blood Clots

What do you think caused your symptoms, injury and/or pain?_____

My symptoms are currently (please circle): GETTING BETTER GETTING WORSE STAYING THE SAME

Aggravating Factors: Can you identify positions or activities that make your symptoms worse? _____

_____

Symptom relieving Factors: Can you identify positions or activities that make your symptoms better? _____

_____

When are your symptoms the worst? (please circle) MORNING AFTERNOON EVENING NIGHT AFTER EXERCISE

When are your symptoms the best? MORNING AFTERNOON EVENING NIGHT AFTER EXERCISE

Patient Signature _____ Date_____