DCH Outpatient Therapy Patient History Form

1. Please check any of the following that apply.

Cardiovascular: ☐ Afib/Arrhythmia ☐ Angina ☐ Coronary Artery Disease ☐ High Cholesterol ☐ Hypertension ☐ Heart Attack ☐ Tachycardia ☐ Valve Disease

Circulatory: ☐ Cellulitis ☐ Deep Vein Thrombosis ☐ Peripheral Vascular Disease ☐ Phlebitis ☐ Pulmonary Embolus

Endocrine: ☐ Diabetes ☐ Hyperthyroidism ☐ Renal/Liver Disease

Hearing/Vision: ☐ Blind ☐ Cataracts ☐ Hard of Hearing ☐ Deaf

Immunological/Infectious Diseases: ☐ Chronic Infection ☐ HIV ☐ Hepatitis

Musculoskeletal: ☐ A vascular necrosis ☐ Degenerative Disc Disease ☐ Disc Bulge ☐ Low Back Pain ☐ Osteoarthritis ☐ Osteoporosis ☐ Rotator cuff tear ☐ Sciatica ☐ Scoliosis ☐ Spinal Stenosis

Cancer: ☐ Breast ☐ Colon ☐ Lymphoma ☐ Prostate

Neurological: ☐ Alzheimer's/Dementia ☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Polio ☐ Reflex Sympathetic Disorder ☐ Seizures ☐ Numbness/Tingling

Psychological: ☐ Anxiety/Panic Disorder ☐ Bipolar Disorder ☐ Depression ☐ Schizophrenia

Pulmonary: ☐ Asthma ☐ CHF ☐ COPD ☐ Pneumonia ☐ Shortness of Breath

Rheumatological: ☐ Fibromyalgia ☐ Juvenile RA ☐ Rheumatoid Arthritis

2. Please list any past medical history not mentioned above:

3. Please list any surgical procedures and date, if possible:

4. Allergies: ☐ Clothing with elastic ☐ balloons ☐ fruits ☐ rubber gloves ☐ condoms or diaphragms ☐ adhesive tape or band aids ☐ Latex ☐ Others not listed:

Drug Reactions:

5. Are you pregnant? ☐ Yes ☐ No ☐ Unsure

6. Check any of the following that you may have: ☐ Pacemaker ☐ Dentures ☐ Contacts ☐ Implants ☐ Metal or foreign objects in body

7. Are you under the care of a physician? ☐ Yes ☐ No If yes, why? _____

8. Please list all medications you are taking:

9. Employment Status ☐ If employed, please list place of employment _____

10. What do you hope to gain as a result of therapy treatment?

☐ Improved Movement ☐ Improved Posture ☐ Decreased Muscle Spasms ☐ Improved Strength
☐ Improved Endurance ☐ Improved Home or Work Ability ☐ Decreased Pain ☐ Improved Walking & Balance

To the best of my knowledge, the foregoing information is accurate and truthful.

Patient Signature: _____ Date (M/D/YEAR) ☐