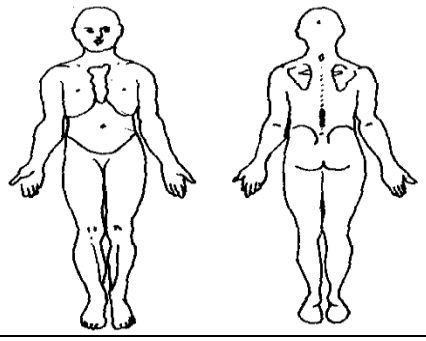
East Oahu Physical Therapy Health History

Name: _____ **Age**: _____

Reason for today's visit/Chief Complaint: _____

PRESENT INJURY/CONDITION

How did symptoms start? What makes symptoms worse? What makes symptoms better?	**Please indicate area(s) of symptom on diagram:** Label: (P) Pain (N) Numbness



On a scale of 0-10 (with 10 being severe pain) how would you rate your symptoms?

Please Circle: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

PAST MEDICAL HISTORY: Please indicate (Y) Yes or (N) No if you have had any of the following health concerns.

High Blood Pressure	Y	N	_____	Diabetes	Y	N	_____
Heart Trouble	Y	N	_____	Stroke	Y	N	_____
Respiratory Issues	Y	N	_____	Tuberculosis	Y	N	_____
Weakness of Muscles	Y	N	_____	Cancer	Y	N	_____
Joint Pain/Stiffness	Y	N	_____	HIV	Y	N	_____
Numbness/Tingling	Y	N	_____	Osteoporosis	Y	N	_____
Convulsions/Seizures	Y	N	_____	Tremors	Y	N	_____
Other	Y	N	_____	Head Injury	Y	N	

Previous Hospitalization/Surgeries/Serious Illness **When?**

_____

_____

_____

Medication (include nonprescription)

_____

_____

FEMALE PATIENTS ONLY: Are your pregnant? Yes *Due date*_____ No

Patient Social History:

Marital Status:	Single: ____	Married: ____	Separated: ____	Divorced: ____	Widowed: ____
Alcohol Use	Never: ____	Rarely: ____	Moderate: ____	Daily: ____	How Much? _____
Tobacco Use:	Never: ____	Previously, but quit.(when) ____		Current Packs/day: _____	

***** TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS CORRECT AND ACCURATE.*****

_____ _____

Patient Signature: Date: