PROACTIVE REHABILITATION

Patient Health History Form

Full Name: ___________________________ **Date of Birth:** _________________

Sex: (please circle) Male Female **Height:**__________ **Weight:**__________

Please describe in detail your current problem/injury.____
____

Which side of the body is affected? (Please circle) Right Left Bilateral

When did the problem begin/injury occur? ____

What were you doing at the time of the injury? ____

Where were you when the injury took place? ____

Were you under the influence of drugs/alcohol at the time of injury? (Please circle) Yes No

Were you being paid at the time of the injury? (Please circle) Yes No

Are you currently being treated by another medical provider for this condition? (Please circle) Yes No

Have you had a surgery related to this condition? (Please Circle) Yes No Date of Surgery: (If Yes) ____________

What is your dominant hand? (Please Circle) Right Left Ambidextrous

Indicate any areas you are experiencing difficulties (check all that apply)

☐ Hygiene	☐ Walking	☐ Fine Hand Use
☐ Sleep	☐ Moving Around	☐ Moving objects with Lower Extremities
☐ Household chores	☐ Transfers (i.e. bed to floor)	☐ Work/Vocation/Occupation
☐ Driving	☐ Negotiating Objects	☐ Recreation
☐ Caregiving	☐ Hand & Arm Use	

Please check each applicable diagnosis:

☐ Impairment of vision or hearing	☐ Pacemaker	☐ Epilepsy/fainting
☐ Diabetes	☐ Osteoporosis	☐ Poor Circulation
☐ Asthma	☐ Drug Allergies	☐ HIV/Hepatitis A,B, C
☐ High blood pressure	☐ Cancer	☐ MRSA
☐ Low blood pressure	☐ Stroke	☐ Heart Problems

Medications (Please list ALL current medications, vitamins, minerals, or dietary supplements):

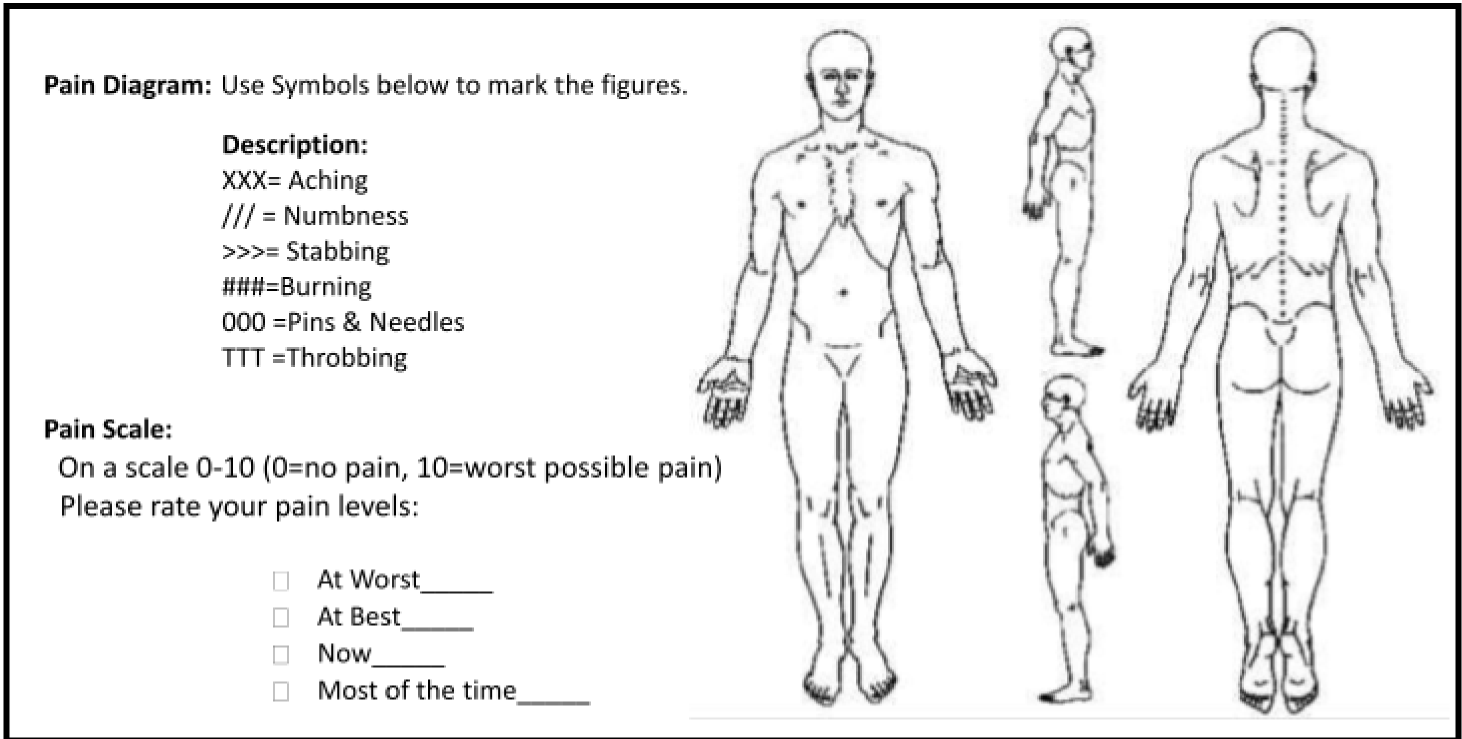
Drug	Dosage	Drug	Dosage

PLEASE TURN PAGE OVER & CONTINUE

Allergy (Please list ALL drug, metal or medical allergies):	**Reaction**

Social History & Mental Health (check all that apply):

Exercise	**Alcohol**	**Tobacco**
☐ Sedentary (No exercise) ☐ Mild Exercise (walking, golf, etc) ☐ Regular exercise (2-3x/wk) ☐ Regular vigorous exercise (4x's/wk)	☐ Drink alcohol ☐ Concerned about the amount you drink How many drinks per week? ______	☐ Use tobacco # of years? ______ Packs per day? ______ Year quit? ______
Drugs	**Personal Safety**	
☐ Currently use recreational or street drugs ☐ Used street drugs with a needle In the past	☐ Live alone ☐ Frequent falls in the last 6 months	



Pain Diagram: Use Symbols below to mark the figures.

Description:
XXX= Aching
/// = Numbness
>>>= Stabbing
###=Burning
000 =Pins & Needles
TTT =Throbbing

Pain Scale:
On a scale 0-10 (0=no pain, 10=worst possible pain)
Please rate your pain levels:

☐ At Worst_____
☐ At Best_____
☐ Now_____
☐ Most of the time_____

I agree that the above information accurately describes my medical history and that should any changes in my medical history occur; I will notify my Physical Therapist immediately.

PATIENT SIGNATURE: ____ **DATE:** _________________________

FOR YOUR PHYSICAL THERAPIST ONLY:

BMI= ________ /_______ ^{2} x 703 =

Weight Height