

Back In Motion Physical Therapy, LLC

Confidential Health History

Please Print Clearly

Patient Name _____ Birth Date ____ / ____ / ____
(last) (First)

Age _____ Height _____ Weight _____ Unexplained recent weight loss or gain? Y or N

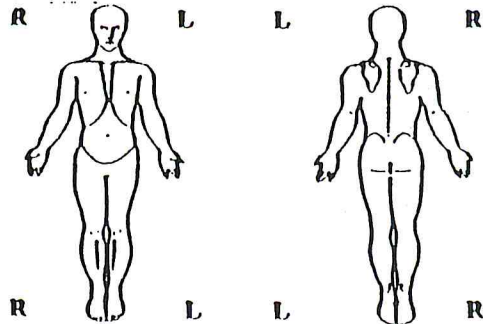
List all medicines you currently take, how much, and how often. _____

List all allergies (including adhesives). _____

Have you ever had a serious illness, accident or broken bones? If yes, please explain and give dates. _____

Have you ever been hospitalized or had surgeries? When and for what? _____

1. Please shade in areas of pain or other symptoms on the body drawing to the right.
2. Please describe below the problem or condition for which you are seeking relief.



**** Please check any of the following conditions that you have, or have had, and give dates.**

Frequent or severe headaches which:

- Start in back of the head
- Are associated with stress

Chest pain/tightness which:

- Begins with physical activity
- Disappears with rest

- Heart attack or heart disease
- Diabetes
- Low blood sugar
- Epilepsy or convulsions
- Stroke (CVA)
- Sudden Weakness of an arm or leg
- Ringing or pain in one or both ears
- Tumor or cancer (if yes, Where?)
- Asthma
- Ulcers or digestive problems

- Impaired memory and/or thought process
- Sudden spells of dizziness or light headedness
- Congenital abnormalities
- Headaches that occur primarily on one side of head
- Nausea and/or vomiting are associated with headaches
- Headaches begin when emotionally stressed
- Headaches associated with allergies or other illness
- Radiates into arm or jaw

- Difficulty swallowing
- Hearing loss
- Osteoporosis("brittle bones")
- Emphysema
- Tuberculosis
- Arthritis
- unexplained joint or muscle pains
- Genital or gynecological disorder/disease
- High/Low blood pressure (circle which)
- Thyroid or other metabolic disorders

Do you have a pacemaker or surgical implant? Are you now pregnant? Do you have a communicable disease?

In consideration of the health and safety of both our patients and staff, this office enforces a policy relating to communicable diseases and conditions, including open or infected wounds. We strongly encourage anyone with a chronic, communicable (or potentially communicable) disease (TB,HIV,AIDS, hepatitis, etc.) or anyone with infected wounds or skin lesions to notify their therapist at their first visit. Your therapist has a legal and ethical responsibility to notify any staff member who will be in direct physical contact with that patient of such a condition. This allows us to take the appropriate precautions for all affected parties. At the patient's request, however, other non-treating staff need not be informed.

Patient Signature _____ Date: _____