Gainesville Physical Therapy & Wellness
"Where People Matter and Results Count"

PATIENT HEALTH HISTORY FORM Page 1 of 3

SOCIAL HISTORY

□ Alone □ Spouse Only □ Spouse and Other(s) □ Child (not spouse) □ Other relative (not spouse or children) □ Group setting □ Personal care attendant □ Other ___________________________________

Have you completed an advance directive? □ yes □ no

PAST MEDICAL HISTORY:

Have you EVER been diagnosed with any of the following conditions or have you recently experienced any of the following?

□ No □ Yes Anxiety
□ No □ Yes Allergies
□ No □ Yes Anemia
□ No □ Yes Arthritic Conditions (not RA)
□ No □ Yes Asthma
□ No □ Yes Cancer (If yes, what kind?)
____
□ No □ Yes Heart Attack/Heart Problems
□ No □ Yes Pace Maker
□ No □ Yes Chemical Dependency (alcoholism)
□ No □ Yes Circulation problems
□ No □ Yes Currently Pregnant?□1st□2nd□3rd Trim.
□ No □ Yes Depression
□ No □ Yes Diabetes
□ No □ Yes Dizziness/lightheadedness
□ No □ Yes Emphysema/Bronchitis
□ No □ Yes Fractures
□ No □ Yes Gall Bladder Problems
□ No □ Yes Hepatitis
□ No □ Yes High Blood Pressure
□ No □ Yes Incontinence/ Difficulty with bowels/Bladder
□ No □ Yes Kidney Disease

□ No □ Yes Metal Implants
□ No □ Yes Multiple Sclerosis
□ No □ Yes Osteoporosis/Osteopenia
□ No □ Yes Parkinson's Disease
□ No □ Yes Rheumatoid Arthritis (RA)
□ No □ Yes Siezures/Epilepsy
□ No □ Yes Speaking Problems
□ No □ Yes Stroke
□ No □ Yes Thyroid Problems
□ No □ Yes Tuberculosis
□ No □ Yes Are you vision impaired?
□ No □ Yes Do you have trouble hearing?
□ No □ Yes Polio
□ No □ Yes Nausea or Vomiting
□ No □ Yes Weight Loss
□ No □ Yes Weight Gain
□ No □ Yes Fatigue
□ No □ Yes Weakness
□ No □ Yes Numbness / Tingling
□ No □ Yes Fever/ Sweats/ Chills
□ No □ Yes Other ____________________

At the present time, would you say your health is □ Excellent □ Very Good □ Fair □ Poor

During the past month have you been feeling down, depressed or hopeless? □ No □ Yes

During the past month have you been bothered by having little interest or pleasure in doing things? □ No □Yes

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? □ No □Yes

How much caffeinated or caffeine containing beverages do you drink per day? _______

How many packs of cigarettes do you smoke a day? _______

How many days per week do you drink alcohol? _______

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ______

Do you have any allergies? ____

What kind of exercise do you do? How often? ____

___________________________ ____

Print Patient Name Signature Date

Gainesville Physical Therapy & Wellness
"Where People Matter and Results Count"

Pick a number 0-4 to measure how much you agree with the following statements.

(0 is completely agree, 4 meaning completely disagree).

"I worry all the time about whether the pain will end" 0 1 2 3 4

"I keep thinking about how much it hurts" 0 1 2 3 4

"There is nothing I can do to reduce the intensity of the pain" 0 1 2 3 4

Which of the follow over-the-counter medications have you taken in the last week?

□ No □ Yes Aspirin
□ No □ Yes Tylenol
□ No □ Yes Advil/Motrin/Ibuprofen
□ No □ Yes Laxatives
□ No □ Yes Other____________________
□ No □ Yes Antihistamines
□ No □ Yes Antacid
□ No □Yes Decongestants
□ No □ Yes Vitamins/mineral supplements

LIST Vitamins/Supplements: ____

____

Please list any PRESCRIPTION are you currently taking (including pills, injections, etc.) and explain what they are used for.

Medications:	**Dosage:**	**Reason**

Do any of your medications cause you to be dizzy or to lose your balance? : □*YES* □*NO*

____________________ ____________________

Print Patient Name Signature Date

PATIENT HEALTH HISTORY FORM Page 3 of 3

INJURIES, HOSPITALIZATIONS, SURGERY
Please describe all injuries and any surgeries for which you have been treated:

Injury / Surgery / Hospitalization	Date	Reason

Has anyone in your immediate family (parents, brothers, sisters) been treated for any of the following?

□ No □ Yes Diabetes
□ No □ Yes Stroke
□ No □ Yes Kidney disease
□ No □ Yes Alcoholism (chemical dependency)
□ No □ Yes Tuberculosis
□ No □ Yes Heart Disease
□ No □ Yes High blood pressure
□ No □ Yes Headaches
□ No □ Yes Epilepsy
□ No □ Yes Mental illness
□ No □ Yes Cancer
□ No □ Yes Arthritis
□ No □ Yes Anemia

Patient Name ____________________

Signature ____________________