Health Status Form

Date: | Patient Name:

Present Complaint: | Date of Onset:

How did injury occur? Please check all that apply:

☐ Accident ☐ Fall ☐ Gradually ☐ Work Injury ☐ Lifting ☐ Sport ☐ Surgery ☐ Other ____________________________

Do you have pain? ☐ Yes ☐ No | Rate Pain (0 no Pain – 10 high pain) At Best: ______________ At Worst: _______________

Have you had physical therapy for this problem before? ☐ Yes ☐ No | If yes, when:

☐ ☐ ☐ ☐ ☐

What tests have been done for this condition? (check all that apply)

☐ CT Scan MRI X Ray EMG Bone Scan Ultrasound ☐ None ☐ Other ___________________________________

Describe your overall general health : ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past Medical History

If yes, please provide details

High Cholesterol • • ___________________________
High Blood Pressure es o ___________________________
Heart Problems • • ___________________________
Seizures/Neurological es o ___________________________
Behavioral/Learning • • ___________________________
Anxiety/Depression es o ___________________________
Genetic/Congenital • • ___________________________
Are you pregnant? es o ___________________________
Bone Joint Problems • • ___________________________
es o
• •
es o
• •
es o
• •
es o
• •
es o

Stroke • • ___________________________
Blood Clots es o ___________________________
Pacemaker • • ___________________________
Cancer/Tumor es o ___________________________
Diabetes • • ___________________________
Hepatitis/HIV es o ___________________________
Asthma/COPD • • ___________________________
Do You Smoke? es o ___________________________
If so, how much? • • ___________________________
es o
• •
es o
• •
es o
• •
es o

Other (describe): ____

Significant Past Surgeries: ____

Medications/Allergies

List all medications (prescription & OTC medication/vitamins) or attach list, include dosage and method: ____
____
____

List all food and medical allergies (include latex & adhesives): ____
____
____

Daily Activities

What do your job and/or home duties require? Check all that apply:

- Computer Work
- Kneeling/Squatting
- Repetitive Movement/Twisting
- Standing
- Walking
- Writing
- Reaching
- Climbing
- Pushing/Pulling
- Carrying
- Lifting
- Other ______________________________________

____
Signature of Patient or Legally Authorized Representative

____
Date