

Name: \_\_\_\_\_ Referred by: \_\_\_\_\_

Birthdate (mm/dd/yyyy): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Occupation: \_\_\_\_\_

**WHAT IS THE REASON FOR YOUR VISIT TODAY?**

**PAST MEDICAL HISTORY:** Please check all that apply, even if your medications have fixed the problem (examples: high blood pressure, high cholesterol, asthma, heart attack, depression, etc).

- |  |  |
|--|--|
| <input type="checkbox"/> High or low blood pressure    | <input type="checkbox"/> Headaches                       |
| <input type="checkbox"/> Heart problems                | <input type="checkbox"/> Stroke or head injury           |
| <input type="checkbox"/> Pacemaker                     | <input type="checkbox"/> Depression                      |
| <input type="checkbox"/> Angina                        | <input type="checkbox"/> Muscular disease                |
| <input type="checkbox"/> Shortness of breath           | <input type="checkbox"/> Seizures, fainting or dizziness |
| <input type="checkbox"/> Asthma/sinus problems         | <input type="checkbox"/> Fractures                       |
| <input type="checkbox"/> Lung problems                 | <input type="checkbox"/> Bursitis/tendonitis             |
| <input type="checkbox"/> Recent gain or loss of weight | <input type="checkbox"/> Arthritis                       |
| <input type="checkbox"/> Liver disease                 | <input type="checkbox"/> Neck/back pain                  |
| <input type="checkbox"/> Kidney/bladder problems       | <input type="checkbox"/> Glasses or contacts             |
| <input type="checkbox"/> Bowel problems                | <input type="checkbox"/> Hearing loss                    |
| <input type="checkbox"/> Thyroid problems              | <input type="checkbox"/> Infectious disease              |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Skin conditions                 |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Smoking history                 |
| <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Other: _____                    |

Have you fallen in the last 6 months?  YES  NO

Do you take any medication that causes you to feel dizzy or unsteady?  YES  NO

**PAST SURGICAL HISTORY:** Please *list prior surgeries with approximate dates*, no matter how long ago (examples: appendectomy, gall bladder removal, tonsillectomy, hip or knee surgery, etc).

OPERATION	YEAR	REASON
1.		
2.		
3.		
4.		
5.		

**Do you have ALLERGIES to medication, food, latex, adhesives?**  Yes  No If yes, please list:

Please list **CURRENT MEDICATIONS** with dosage (including aspirin, advil, and multivitamins)

- |    |    |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |



**OUTPATIENT THERAPY HISTORY FORM**



**MOST RECENT HOSPITALIZATION DATES:** \_\_\_\_\_

**REASON(S) FOR HOSPITALIZATION:** \_\_\_\_\_

**PREVIOUS THERAPY FOR CURRENT CONDITION:**

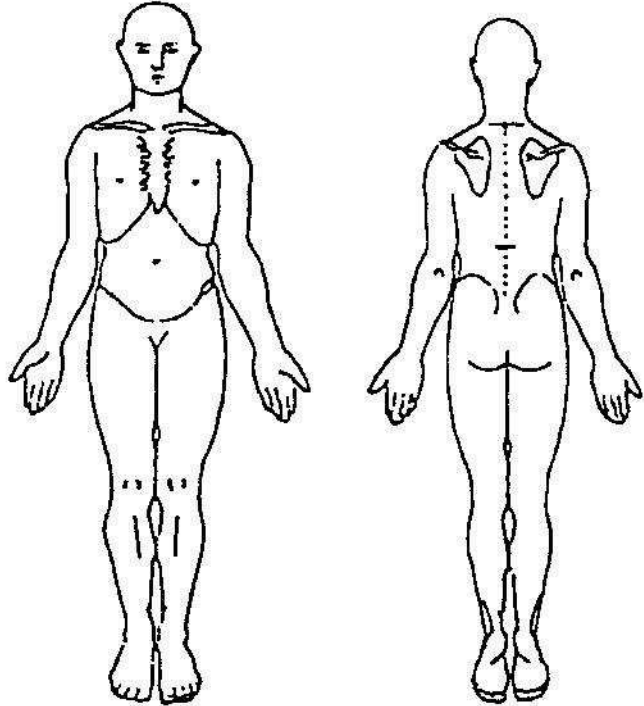
Mark the location(s) of your pain with an "x" on the diagram. If whole areas are painful, shade in the painful area.  
? Areas of numbness

Indicate your pain type by circling a letter or letters

- A Deep (inside)
- B Superficial (on the skin)
- C Constant (all the time)
- D Intermittent (starts & stops)
- E Aching
- F Burning
- G Shooting
- H Numbness
- I Other

Please rate your pain by circling on the scale below, with "0" being no pain, and "10" being excruciating pain.

0 1 2 3 4 5 6 7 8 9 10



How would you describe the pain?

What makes it better?

What makes it worse?

**Current Symptoms (please check all that apply)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Numbness or tingling     | <input type="checkbox"/> Weakness/fatigue        | <input type="checkbox"/> Chronic coughing          |
| <input type="checkbox"/> Extremity swelling       | <input type="checkbox"/> Loss of balance/falling | <input type="checkbox"/> Difficulty swallowing     |
| <input type="checkbox"/> Cold extremities         | <input type="checkbox"/> Coordination problems   | <input type="checkbox"/> Hoarseness                |
| <input type="checkbox"/> Blurred or double vision | <input type="checkbox"/> Sleeplessness           | <input type="checkbox"/> Night sweats/chills/fever |
| <input type="checkbox"/> Memory loss              | <input type="checkbox"/> Concentration problems  | <input type="checkbox"/>                           |

I learn better by:  Hearing  Reading  Pictures  All

Form completed by: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

**Please tell your therapist of any new medical diagnosis, invasive procedures, allergies or medication changes during this treatment period.**



**OUTPATIENT THERAPY HISTORY FORM**

