CURRENT HEALTH HISTORY

NAME _______________________________________ DOB ________________ DATE ______________

ADDRESS ________________________ CITY_____________________ STATE _______ ZIP ___________

CELL PHONE _______________________________ WORK PHONE ______________________________

PREFERRED E-MAIL ADDRESS ______________________________

IN CASE OF EMERGENCY __________________________________ PHONE _______________________

OCCUPATION____
EMPLOYER________________________

PRIMARY CARE SPECIALIST________________________ REFERRING PHYSICIAN___________________

***If you have referred yourself to physical therapy, Indiana state law requires a physician's order after 24 consecutive calendar days. (IC 25-27-1-2.5)

1. Describe the primary issue/problem that brought you here today: ____ ____ ______________________.

2. When did your problem first begin? ____.

3. Was your first episode of the problem related to an accident or specific incident? Yes/No

   If yes, please describe: ____

____
________________________.

4. Is your problem staying the same____, getting better____, getting worse____?

5. If pain is present, rate it on a 0-10 scale (0=no pain, 10=extreme pain):

______At its worst ______At its best ______At present ______At night (sleeping)

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6. Please describe the nature of your pain (burning, stabbing, etc.): ____
____________.

7. Describe any previous treatments that you have received for this problem: ____
____
________________________.

8. Activities that cause/aggravate your symptoms:

Please check all that apply

___Sitting greater than ______minutes

___Walking greater than ____minutes

___Standing greater than ____minutes

___Changing positions (sit to stand)

___Vigorous activity (exercise/work)

___With triggers (key in the door, running water)

_____With cough, sneeze, straining

_____With laughing/yelling

_____With lifting/bending

_____Light activity (light housework)

_____With cold weather

_____With nervousness/ anxiety

___Sexual activity (oral sex, manual stimulation, superficial penetration, deep penetration)

___**Wearing tight clothing (underwear, tight pants, blue jeans, etc.)**

___**Inserting/attempting to insert a tampon**

___**Other, please describe**____.

___**No activity affects the problem**

9. **What relieves your symptoms?**
____
____
_________________________.

10. **At what time of the day are your symptoms the worst?**
___________________________________.

11. **At what time of day are your symptoms the best?**
____.

12. **How has your lifestyle/quality of life been altered because of this problem?**
____
____
____
_____________________________________.

13. **Rate the severity of this problem (0=no problem, 10=the worst)**
____________________________.

14. **What are your treatment goals?**
____
____
_________________________.

15. **What are your concerns, if any, related to this problem?**
____
____
____________.

GENERAL HEALTH HISTORY

Date of last physical exam____________________ who did you see_____________________________?

Where any tests performed? Yes/No

____.

General Health: Excellent Good Average Fair Poor

Mental Health: Currently seeing a psychologist/psychiatrist? Yes/No

Current level of stress: High Medium Low

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

What type of exercise ____?

Is your current problem/issue preventing you from exercising? Yes/No

Do you have discomfort, shortness of breath, or pain with exercise? Yes/No

Do you smoke? Yes/No

If yes, how many per day? ____

If yes, would you like to quit? ____

If no, did you smoke in the past? ____

Is there a chance you may be pregnant now? Yes/No

Sleep: Do you have trouble falling asleep? Yes/No

Is your sleep restful? Yes/ No

Do you find it difficult to lie down? Yes/ No

Do you find it difficult to change positons in bed? Yes/No

How many times do you wake per night? ____

How long before you fall back to sleep? ____

Have you ever had any of the following conditions or diagnoses?

Please circle all that apply:

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple Sclerosis	Allergies
Ankle Swelling	Head injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/Hyperthyroid

Low back pain Chronic Fatigue Syndrome Headaches

Sacroiliac/Tailbone pain Fibromyalgia Diabetes

Alcoholism/drug problem Arthritis Kidney disease

Childhood bladder issues Stress fracture Irritable Bowel Disease

Depression Rheumatoid Arthritis Hepatitis

Anorexia/bulimia Joint Replacement Sexually transmitted disease

Bone fracture Physical or Sexual Abuse Vision/eye problems

Sports injuries TMJ/neck pain Raynaud's (cold hands & feet)

Pelvic pain Hearing loss/problems HIV/AIDS

Suicidal thoughts Abortion Liver disease

Other/ describe____

Surgical History:

Surgery for your back/spine Yes/No Surgery for your bladder/prostate Yes/No

Surgery for your brain Yes/No Surgery for your bones/joints Yes/No

Surgery for your abdominal organs Yes/No Surgery for your female organs Yes/No

Other/please describe____

Ob/Gyn History (females only):

Childbirth/vaginal deliveries #___ Yes/No Vaginal dryness Yes/No

Episiotomy #___ Yes/No Painful periods Yes/No

C-section #___ Yes/No Menopause Yes/No

Difficult childbirth #___ Yes/No Painful vaginal penetration Yes/No

Pelvic pain Yes/No Prolapse/organ falling out feeling Yes/No

Other____

Males Only:

Prostate disorder Yes/No Erectile dysfunction Yes/No

Shy Bladder	Yes/No	Painful ejaculation	Yes/No
Pelvic pain	Yes/No	Painful bowel movements	Yes/No