



FERNLEY PHYSICAL THERAPY, INC.

HEALTH HISTORY FORM

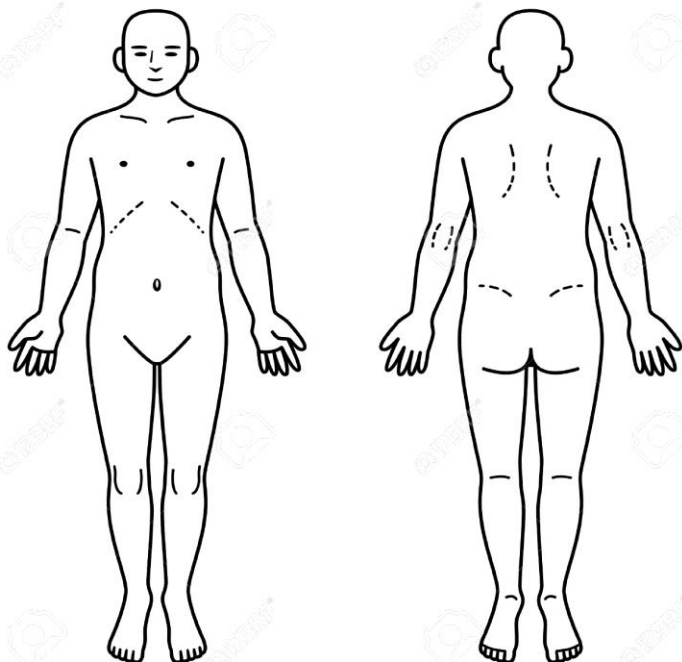
NAME			DATE		
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DOB		HEIGHT		WEIGHT	
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ARE YOU PREGNANT?		TRIMESTER		NAME OF OG/GYN	
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PRIMARY PROBLEM/SYMPTOM:

SIDE OF INJURY	LEFT	RIGHT	DATE OF INJURY/ONSET OF PAIN		HAVE YOU HAD A SIMILAR INJURY BEFORE?	
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PLEASE CIRCLE THE AREAS ON THE ABOVE DRAWING WHERE YOU HAVE PAIN.

HAVE YOU HAD SURGERY FOR THIS CONDITON? YES NO
 DATE OF SURGERY? _____

CIRCLE THE APPLICABLE RESPONSE.

IS YOUR PAIN
 CONSTANT INTERMITTANT?

WORSE IN THE
 AM PM?

DOES YOUR PAIN KEEP YOU AWAKE A
 NIGHT? YES NO

USING A SCALE OF 1 TO 10 WHERE 0 =
 NO PAIN AND 10 = SEVERE PAIN, RATE
 YOUR PAIN LEVEL WHEN YOU ARE
 RESTING _____
 AND WHEN YOU ARE PERFORMING
 ANY KIND OF ACTIVITY _____

WHAT EASES YOUR PAIN?

WHAT ACTIVITIES INCREASE YOUR
 PAIN?

IS YOUR CURRENT LEVEL OF ACTIVITY	HIGH	MEDIUM	LOW	DESCRIBE:
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WHAT ACTIVITIES ARE LIMITED BY THIS INJURY/PAIN?										
WHICH OF THE FOLLOWING DESCRIBE YOUR PAIN? MARK ALL THAT APPLY.	SHARP		ACHY		BURNING		TINGLING		NUMBNESS	
	OTHER:									
ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES/NO. IF YES PLEASE LIST NAME AND DOSAGE.										
WAS THIS INJURY THE RESULT OF A FALL? YES/NO	HAVE YOU FALLEN TWICE OR MORE IN THE PAST YEAR? YES/NO									
DO YOU SMOKE? YES /NO	DO YOU DRINK ALCOHOL? YES/ NO									
HAVE YOU BEEN DIAGNOSED WITH ANY OF THE CONDITIONS BELOW?										
ALLERGIES	YES	NO	DEFIBRILATOR	YES	NO	MIGRAINES	YES	NO		
ARTHRITIS	YES	NO	DIABETES	YES	NO	MULTIPLE SCLEROSIS	YES	NO		
ASTHMA	YES	NO	DIZZINESS/VERTIGO	YES	NO	OSTEOPOROSIS	YES	NO		
ANXIETY	YES	NO	EMPHYSEMA	YES	NO	PACEMAKER	YES	NO		
BLOOD CLOTS	YES	NO	FIBROMYALGIA	YES	NO	PARKINSON'S	YES	NO		
BRAIN INJURY	YES	NO	FRACTURES	YES	NO	SEIZURES	YES	NO		
CANCER	YES	NO	HEARING ISSUES	YES	NO	STROKE	YES	NO		
CARDIAC DISEASE	YES	NO	HEPATITIS	YES	NO	THYROID PROBLEMS	YES	NO		
			HIGH BLOOD PRESSURE	YES	NO					
LIST ALLERGIES:										
LIST SURGERIES:										
CONSENT FOR CARE AND TREATMENT										
I, _____, HEREBY AGREE AND GIVE MY CONSENT TO FERNLEY PHYSICAL THERAPY, INC. TO PROVIDE THE NECESSARY PHYSICAL THERAPY CARE AND TREATMENT WHEN EVALUATING OR TREATING MY CONDITION.										
SIGNATURE _____ DATE _____										
FOR MINORS ONLY:										
AS PARENT/LEGAL GUARDIAN OF _____, I AUTHORIZE FERNLEY PHYSICAL THERAPY, INC. TO PROVIDE THE NECESSARY PHYSICAL THERAPY CARE AND TREATMENT TO THE MINOR WHEN EVALUATING OR TREATING HIS/HER CONDITION. I ALSO AUTHORIZE THE TREATMENT OF THE ABOVE NAMED MINOR WHILE I AM NOT PRESENT.										
SIGNATURE: _____ DATE _____										