HEALTH HISTORY

Today's Date: _____

Name: _____ Date Of Birth: _____

In order to aid us in the selection of the proper treatment program, we ask that you complete the following health screening.

Do you have any of the following health conditions?

Rheumatoid Arthritis	Yes	No	Emphysema	Yes	No	Heart Problems	Yes	No
Osteoarthritis	Yes	No	Asthma	Yes	No	Cancer	Yes	No
Gout	Yes	No	Epilepsy	Yes	No	Mental Illness	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No	Head Injury	Yes	No

Have you experienced any of the following symptoms?

Stiffness or painful joints/muscles?	Yes	No	Swelling in the feet or ankles?	Yes	No
Headaches (frequent)?	Yes	No	Unusual bleeding?	Yes	No
Chest or jaw discomfort with exertion?	Yes	No	Easy bruising?	Yes	No
Buzzing or ringing in the ears?	Yes	No	Are you taking any blood thinner?	Yes	No
Dizziness?	Yes	No	Do you have a pacemaker?	Yes	No
Earaches (frequent)?	Yes	No	Do you have any metal implants?	Yes	No
Shortness of breath with exertion?	Yes	No	Are you pregnant?	Yes	No
			Do you smoke?	Yes	No

Please list any over-the-counter and prescribed medications you are presently taking

(Attach another sheet if necessary):

Medication	Dosage & Times per Day Taken	Medication	Dosage & Times per Day Taken

Do you have any allergies? Yes No If YES, please list _____

Have you undergone any surgical procedure other than what you are currently being treated? Yes No
If YES, please list_____

Are there any other conditions or symptoms for which you have or are currently being treated? Yes No
If YES, please list_____

Has your physician ever indicated that you cannot exercise or perform other activities (I.e. jogging, swimming, lifting) or specified any job restrictions? Yes No If YES, please list _____

Have you received physical, occupational or speech therapy services in the current calendar year at another location/facility?
Yes No If YES, please list_____

_____ _____

Patient's Signature Therapist's Signature

Pain Rating Scale:

Instructions

Please rate your major area of pain on the 0 - 10+ Pain Rating Scale by writing the number of your pain, considering the descriptions provided, at the present time, at your best and at your worst over the past 30 days.

Also, indicate the area where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are NOT related to your present injury or condition.

Pain Rating	Now _____
Over Past 30 Days	Best _____
Over Past 30 Days	Worst _____

Level of Pain:

10+	Maximal Pain
10	Very, Very Strong Pain
9	
8	
7	Very Strong Pain
6	
5	Strong Pain
4	Somewhat Strong Pain
3	Moderate Pain
2	Weak Pain
1	Very Weak Pain
0	No Pain

Areas of Pain:

IIIII	Stabbing Pain
xxx	Burning Pain
000	Pins and Needles Pain
===	Numbness