Bodywor
Physical Therapy

Health History

Name:____________________ DOB:__________ Age:__________

E-mail____________________

Your Employer:____________________ Occupation:____________________

Work Number:__________ Family Physician:____________________

Emergency Contact Name:____________________ Phone:____________________

Relationship:__________

How did you hear about us?:____________________

What are your goals? What do you want to accomplish with Physical Therapy?:____________________

____

Have you ever had previous treatment for this problem?:__________ If yes, please explain:____________________

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Basic Health History: (Please check all that apply)

- ☐ Diabetes
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Breathing Problems
- ☐ Pace Maker
- ☐ Scoliosis
- ☐ Neurological disorders (polio, M.S., A.L.S., etc.)
- ☐ Back or neck problems
- ☐ Joint pain or problems
- ☐ Impaired hearing
- ☐ Impaired vision
- ☐ Recent antibiotic use
- ☐ Frequent urination (more than 8x/day)
- ☐ Difficulty holding bowel or bladder
- ☐ Smoke
- ☐ Illegal drug use
- ☐ Allergies:__________
- ☐ Other: __________

For Women Only:

☐ Currently pregnant (or trying) ☐ Pelvic/rectal pain ☐ Painful intercourse

Please list all medications & supplements you are currently taking:____________________

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Please list any surgeries you have had:____________________

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Patient signature:____________________ Date:____________________

Re-occurring patients only:

Please list any changes in your health history:

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____________________ Initial:__________ Date:____________________