Bodyworx
Physical Therapy &
Concussion Center

HEALTH HISTORY

Name:_____DOB:_____Age:_____
E-mail:_____ Cell Phone:_____
Your Employer:_____ Occupation:_____
Work Number:_____Family Physician:_____
Emergency Contact Name:_____Relationship:_____Phone:_____

- How did you hear about us?_____
- What are your goals? What do you want to accomplish at Bodyworx?_____
  _____
- On a scale of 1 to 10, how would you rate your motivation to reach these goals? _____
- Have you ever had previous treatment for this problem?_____If yes, please explain:_____
  _____
- What are your health or fitness goals for the coming year? _____
  _____

Basic Health History: (Please check all that apply)

☐ Diabetes	☐ Heart Disease	☐ Impaired hearing	☐ Frequent urination (more than 8x/day)
☐ Cancer	☐ Breathing Problems	☐ Impaired vision	☐ Difficulty holding bowel or bladder
☐ HIV/AIDS	☐ Pace Maker	☐ Recent antibiotic use	☐ High Stress Level:_____
☐ Hepatitis	☐ Scoliosis	☐ Smoke	☐ Trouble Sleeping:_____
☐ Arthritis	☐ Back or neck problems	☐ Illegal drug use	
☐ Osteoporosis	☐ Joint pain or problems	☐ Allergies:_____	

☐ Neurological disorders (polio, M.S., A.L.S., etc.) _____

For Women Only:

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

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

Please list any surgeries you have had:_____
_____
_____
_____

Patient signature:_____Date:_____

Re-occurring patients only:

Please list any changes in your health history:_____
_____
_____Initial:_____Date:_____