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/Asthma**	Yes	No	**Lupus**	Yes	No
Osteoarthritis	Yes	No	**Diabetes**	Yes	No	**Gout**	Yes	No
Heart Problems	Yes	No	**History of Cancer**	Yes	No	**Epilepsy**	Yes	No
High Blood Pressure	Yes	No	**Immunosuppression**	Yes	No	**Infection**	Yes	No
Cerebral Vascular Accident	Yes	No	**Mental Illness**	Yes	No	**Head Injury**	Yes	No
Alzheimer's/Parkinson's	Yes	No	**Fracture (suspected)**	Yes	No	**Fibromyalgia**	Yes	No
Lyme's Disease	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 Name, 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:

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