APEX
Physical Therapy & Wellness Center

Health History

Patient Name: _____ **Date:** _____

1. **What is the primary complaint you are being seen for? Please be specific and give a brief description.**

_____

2. **When did this problem begin? (date or best estimate if unknown)?** _____

3. **What type of injury is it?**

☐ New Injury ☐ Previous Injury ☐ Post Surgical
☐ Auto Injury ☐ Worker's Compensation ☐ Other

If other, please describe: _____

4. **How did the problem occur? (home, work, competitive sports, recreational activities, etc.)**

_____

_____

5. **Have you had any treatment for this problem prior to today?**

☐ None ☐ Physical Therapy ☐ Surgery
☐ Medication/Injections ☐ Chiropractic ☐ Other

If other, please describe: _____

6. **Have you had any special tests for this problem?**

☐ None ☐ CT Scan ☐ X-rays
☐ MRI ☐ EMG ☐ Bone Scan ☐ Other:

If other, please describe: _____

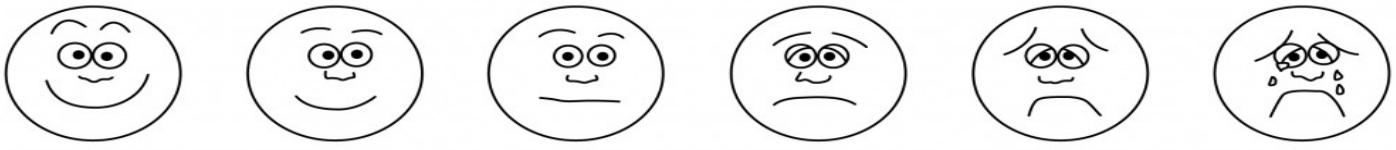
7. **Test Results (skip if no tests performed):** _____

8. **Please describe your current symptoms (check all that apply)**

☐ Sharp Pain ☐ Dull Pain ☐ Burning ☐ Tingling ☐ Dizziness
☐ Nausea ☐ Aching ☐ Numbness ☐ Constant ☐ Intermittent
☐ Other: _____

9. **Is your pain worse in the…** morning mid-day evening night

10. **On a scale of 0-10 (0 being no pain, 10 being extreme pain) rate your pain?** (please circle)



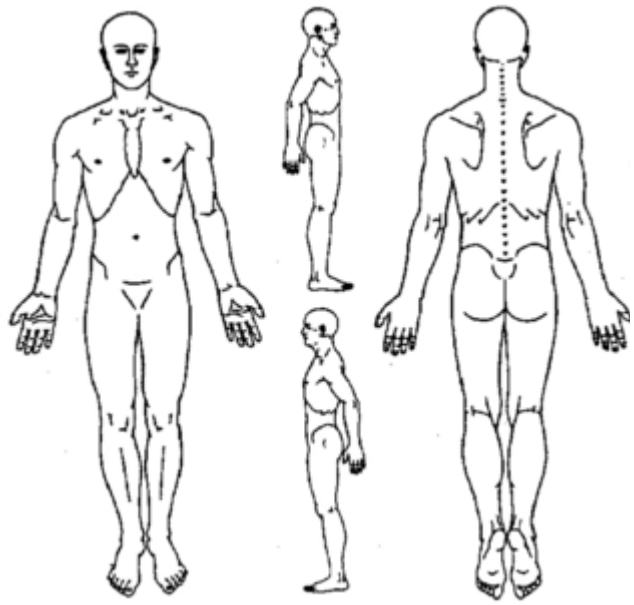
0	1	2	3	4	5	6	7	8	9	10
No Hurt		Hurts Little Bit		Hurts Little More		Hurts Even More		Hurts Whole Lot		Hurts Worst

Flip Over

11. What affects your pain?

	Better	Worse	Same
Ice	☐	☐	☐
Heat	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Rising from Sitting	☐	☐	☐
Position Changes	☐	☐	☐
Sleeping	☐	☐	☐
Lying Down	☐	☐	☐
Coughing / Sneezing	☐	☐	☐
With Activity	☐	☐	☐
After Activity	☐	☐	☐
Rest	☐	☐	☐

12. Please mark painful areas with an X.



13. Please list any surgeries you have had, including implantations (i.e. IUD, pacemakers, pain pump, lap band, clips, mesh staples, etc.)

_____ Date: _____

_____ Date: _____

_____ Date: _____

14. Please circle any of the following health conditions that you <u>have or had</u> in the past.

☐	None	☐	Depression	☐	High Blood Pressure	☐	Multiple Sclerosis	☐	Smoker
☐	Allergies	☐	Diabetes	☐	History of Fracture	☐	Osteoarthritis	☐	Stroke
☐	Anemia	☐	Emphysema	☐	Incontinence	☐	Osteoporosis	☐	Thyroid Disease
☐	Asthma	☐	Fibromyalgia	☐	Kidney Disease	☐	Overweight	☐	Tuberculosis
☐	Cancer	☐	Heart Problems	☐	Menopause	☐	Rheumatoid Arthritis	☐	Unexplained Weight loss
☐	Chemical Dependency	☐	Hepatitis	☐	Mental Illness	☐	Seizures		
☐	Pregnancy; # of pregnancies:_____ # of deliveries:_____					☐	Other: _____		

15. What is your employment status?

☐ Employed: Position: (please write) _____ ☐ Full-Time ☐ Part-Time / PRN

☐ Student ☐ Homemaker

☐ Unemployed ☐ Retired ☐ Disabled

16. If employed, do you have any restrictions at work? _____

17. What are your primary job tasks? (check all that apply)

☐ Prolonged Sitting ☐ Prolonged Standing ☐ Lifting

☐ Repetitive Tasks ☐ Operating a Machine ☐ Driving

☐ Other: _____

18. Please rate your overall Health

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Would you like help and/or information on improving your overall health? ☐ Yes ☐ No