Heinen Physical Therapy, PC

Patient History Form

Please print Clearly, thank you.

Last _____First _____ Phone # _____
Address:_____ State:_____ Zipcode: _____ Email: _____
Social security#:_____Race:_____ Language:_____
Do you have any barriers to learning? Yes/ No If yes please explain: _____

Emergency Contact

First Name _____Last_____ Phone Number: _____

Employer:

Name of company: _____Phone Number _____
Is this a work related injury? Yes / No Occupation:_____

Physician Information

Name: _____ Phone: _____
Address _____ City_____ State_____ Zip_____
May we send a copy of your consultation, and consult with the physician listed and any other Physicians Involved in your care as needed to insure quality care? (circle one) YES NO
Address: _____ City_____ State_____ Zip_____

Insurance Information

Insurance: _____ ID #_____Group #_____
First _____Last _____Birthdate_____
Phone: _____ Social Security # _____ Relationship _____

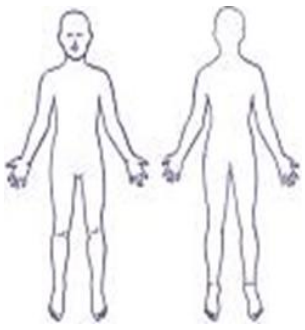
Gender: M / F
Birthdate:_____
Smoker: Yes / No
Pregnant: Yes / No
Married: Yes / No

How would you rate your general health? Excellent Good Fair Poor
Do you exercise at least 3 times/week? Y / N
Past surgeries: (list & date)_____
_____
Current medications (prescription, over-the-counter):_____
_____

Past Medical History: Have you ever been told you have any of the following?

Cancer	Yes	No	Ulcers	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other _____		

Body Chart:



Mark the areas where you feel symptoms.

Turn Over

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Changes in bowel or bladder function	
Dizziness	Nausea/vomiting	Night pain	Headaches Other:_____

How have you been sleeping at night? _____Fine _____Disturbed _____only with medication

During the past month, have you been bothered by feeling down, depressed or hopeless? Y / N

During the past month, have you had little interest or pleasure in doing things? Y / N

Current History:
What date (approximately) did your present symptoms start? _____

How? (gradually, suddenly, injury) _____

How have your symptoms changed?: getting better about the same getting worse

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) _____

What treatments have you received for this problem so far? _____

On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0 1 2 3 4 5 6 7 8 9 10
Cannot do anything Able to do everything

Aggravating Factors: Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

1) _____
2) _____
3) _____

During the past 3 months, have you seen any medical professional (physician, physical therapist, osteopath, etc)? Yes / No If yes, please describe the reason:

_____

Any Additional Injuries that need our attention?

_____

What are your personal goals for Physical therapy?

_____

The information I have provided above is accurate and complete to the best of my knowledge.

_____ _____
(signature) (date)