ATP Physical Therapy Health History

Today's Date: ___________ Patient Name: _________________________ Birthday: ___________ Age: _____

Reason for today's visit/Chief Complaint: ____

PRESENT INJURY/CONDITION:

How did symptoms start?

What makes symptoms worse?

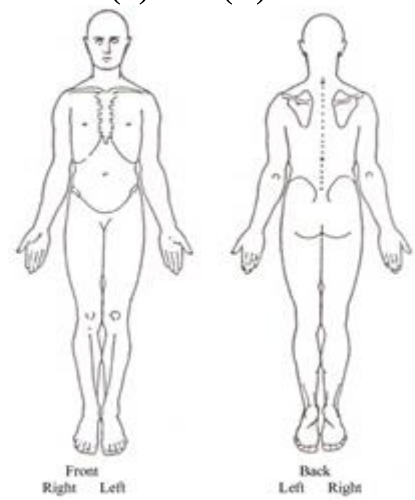
What makes symptoms better?

How would you rate your symptoms?

MILD MODERATE SEVERE

Please indicate area(s) of symptom(s) on diagram:

Label: (P) Pain (N) Numbness



Past Medical History: Please indicate (Y) Yes or (N) No if you have had any of the following health concerns.

High Blood Pressure	Y N ___________	Diabetes	Y N ___________
Heart Trouble	Y N ___________	Stroke	Y N ___________
Chest Pain	Y N ___________	Tuberculosis	Y N ___________
Heart Murmur	Y N ___________	Cancer	Y N ___________
Respiratory Issues	Y N ___________	HIV	Y N ___________
Weakness of Muscles	Y N ___________	Osteoporosis	Y N ___________
Joint Pain/Stiffness	Y N ___________	Tremors	Y N ___________
Numbness/Tingling	Y N ___________	Head Injury	Y N ___________
Cold Extremities	Y N ___________	Convulsions/Seizures	Y N ___________
Bleeding Problems	Y N ___________	Pacemaker	Y N ___________
Other	Y N ____		

Previous Hospitalization/Surgeries/Serious Illness______________________________**When?**_____________

____

____

Medication (include nonprescription)____

____

____

ARE YOU ALLERGIC TO LATEX? YES NO

FEMALE PATIENTS ONLY: Are you pregnant? Yes, Due date_________________ No

Childbirth Information: Dates and Types of Delivery (Vaginal or C section) _____________________________

____

Patient Social History:

Marital Status: Single:_______ Married:_______ Separated:_______ Divorced:_______ Widowed:_______

Alcohol Use: Never:_______ Rarely:_______ Moderate:_______ Daily:_______ How Much:__________

Tobacco Use: Never:_______ Previously, but quit. (when)________ Current Packs/day:________________

Drug Use: Never:_______ Previously, but quit. (when)________ Current use:________ Type?_________

***** TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS CORRECT AND ACCURATE.*****

____ _______________________

Patient Signature: Date: