General Health Review

Name: _____ Date:_____ Age: _____ Height: ____ Weight:____

Referring Physician/Primary Care Provider: _____ Date of Last Visit:_____

How did you hear about our clinic (circle one): Physician, Friend/Family, Internet, Returning Patient

Have you recently experienced any of the following (check all that apply):

□ Night Pain
□ Unexplained Weight Change
□ Bowel/Bladder Dysfunction
□ Shortness of Breath
□ Fever or Chills
□ Night Sweats
□ Changes in urinary frequency
□ Numbness or Tingling
□ Muscle Weakness
□ Loss of Energy
□ Dizziness/Light-headedness
□ Nausea or Vomiting
□ Changes in Appetite
□ Pain when urinating
□ Constipation
□ Difficulty Swallowing
□ Vision Irregularities
□ Fainting
□ Headaches
□ Increased Stress

Have you ever been diagnosed with any of the following medical conditions (check all that apply):

□ Heart Disease
□ Cancer
□ Diabetes (Type I or II)
□ Angina/Chest Pain
□ Stroke/TIA
□ Osteoporosis/Osteopenia
□ Respiratory Disease
□ Circulatory Disease
□ Infectious Disease
□ Bleeding Disorder
□ Thyroid Disease
□ Arthritis
□ Allergies
□ Substance Use Disorder
□ Kidney Disease
□ Seizures
□ Depression
□ Fibromyalgia

Please comment on selections: _____

_____

If you have any other health issues we should know about, please explain:_____

_____

Please describe any major or recent surgeries (type and year):_____

_____

Please list any medications you are currently taking (Prescribed or Over the Counter):_____

_____

FOR WOMEN: Are you currently pregnant or think you might be pregnant: *Yes* *No*

During the past month, have you been feeling down, depressed, or hopeless? *Yes* *No*

During the past month, have you been bothered by having little interest or pleasure in doing things? *Yes* *No*

Is this something with which you would like help? *Yes* *Yes, but not today* *No*

How many times have you fallen in the past year? _____ Date of most recent fall (roughly):_____

Do you smoke? *Yes* *No* Have a history of smoking? *Yes* *No* Packs/day:_____ # of years:____

Do you drink alcoholic beverages? *Yes* *No* Drinks/week:_____ OR Drinks/day:_____

Current Symptom(s) Review

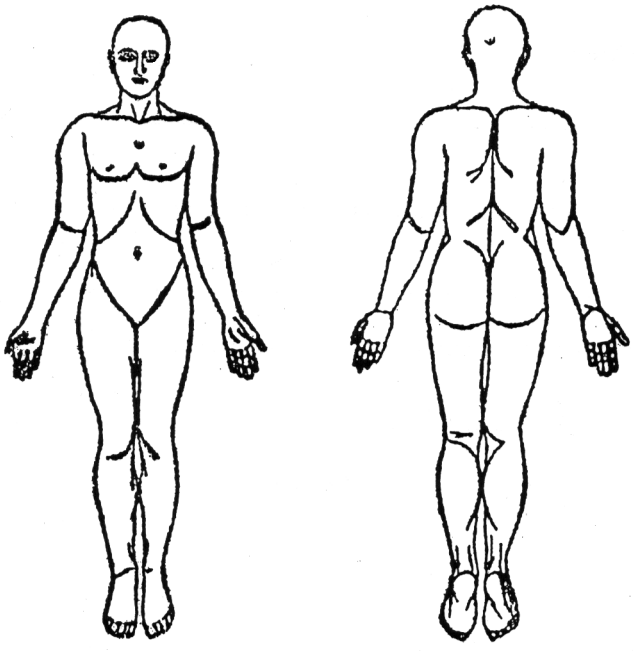
On what date did your current symptoms start (approximately)? _____

What do you think caused your current symptoms or problem? _____

Have you ever had this problem before? If yes, please describe when and how you addressed it:

_____

Please mark the areas where you are experiencing symptoms:



How would you describe your pain:
□ Burning
□ Sharp
□ Dull/Achy
□ Throbbing
□ Shooting
□ Numb/Tingling
□ Other:_____

Does your pain:
□ Come and go
□ Stay constant
□ Stay constant, but worsen with activity

On a scale of 0 to 10, with 0 being "no pain" and 10 being "worst pain imaginable," please rate your:

- *Current* level of pain: _____
- Worst pain in the *last 2 weeks*: _____
- Best pain in the *last 2 weeks*: _____
- Your worst and best pain in the *last 24 hours*: _____&_____

Please list any activities, movements, positions, etc. that *aggravate* your symptoms (make them worse):

_____

_____

Please list any activities, movements, positions, etc. that *ease* your symptoms (make them better):

_____

_____

Do you have any specific goals that you would like to accomplish through physical therapy?

_____

_____