RESILIENCE
PHYSICAL THERAPY AND WELLNESS

PATIENT HISTORY FORM

Date: ____/____/_____ ☐ Minor (under 18 years old)

NAME: _____ Birthdate: ____/____/_____
Last First MI

Age: _____ Sex: ☐ F ☐ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Date of Onset: ____/____/_____
Describe the cause of onset of symptoms:

Please list the names of the other practitioners and treatments you have received you for this problem:

Testing preformed: ☐ X-rays ☐ MRI ☐ CT ☐ Ultrasound ☐ EMG/NCV ☐ other _____

Have you been hospitalized for your current condition? ☐ No ☐ Yes, when and what hospital?

Have you had surgery for your current condition? ☐ No ☐ Yes, when and what surgical procedure?

Do you smoke? ☐ No ☐ Yes, _____ packs per day and for _____ years
Do you drink alcohol? ☐ No ☐ Yes, _____ drinks per day/week and for _____ years
Current or Past substance (legal or illegal) abuse? ☐ No ☐ Yes, last used and what substance? _____

CURRENT MEDICATIONS

Drug allergies: ☐ No ☐ Yes, To what? _____
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of Drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDIAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type)_____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke or TIA
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or Peptic Ulcer
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Allergies: _____

Other medical conditions (please list) _____

_____

SURGICAL HISTORY

List Surgeries and Dates: _____

_____

_____

PERSONAL HISTORY

Were there problems with your birth? ☐ No ☐ Yes, be specific _____

Where were you born & raised? _____

What is your highest education? ☐ Elementary ☐ Junior High School ☐ High School ☐ Some College ☐ College Graduate ☐ Advance Degree

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/Significant Other

What is your current or past occupation? _____

Are you currently working? ☐ No ☐ Yes If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ No ☐ Yes, for what disability & how long? _____

Religion:

HOME & MEDICAL

Home setting: ☐ Single Story House ☐ ☐ Condo ☐ Apartment ☐ Other_____

# of Stairs/Steps at Home: ____ ☐ ☐ Elevator

Bathroom: ☐ Walk in Shower ☐ Tub Shower ☐ Tub only

Medical Equipment: ☐ Cane ☐ Walker ☐ Hand Rails ☐ Lift ☐ Other _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ☐ Recent Weight Gain; ____lbs
- ☐ Recent Weight Loss; ____lbs
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night Sweats

MUSCLE/JOINTS/BONES
- ☐ Numbness
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Joint Swelling

Where?

EARS
- ☐ Ringing in Ears
- ☐ Loss of Hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of Vision
- ☐ Double or Blurred Vision
- ☐ Dryness

THROAT
- ☐ Frequent Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Pain in Jaw

HEART & LUNGS
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Swollen Legs or Feet
- ☐ Cough

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or Loss of Consciousness
- ☐ Numbness or Tingling
- ☐ Memory Loss

STOMACH & INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Yellow Jaundice
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Black Stools

SKIN
- ☐ Redness
- ☐ Rash
- ☐ Nodules/ Bumps
- ☐ Hair Loss
- ☐ Color Changes of Hands or Feet

BLOOD
- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine

Women Only:
- ☐ Abnormal Pap Smear
- ☐ Irregular Periods
- ☐ Bleeding Between Periods
- ☐ PMS

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Difficulty with Sexual Arousal
- ☐ Poor Appetite
- ☐ Food Cravings
- ☐ Frequent Crying
- ☐ Sensitivity
- ☐ Thoughts of Suicide/Attempt
- ☐ Stress
- ☐ Irritability
- ☐ Poor Concentration
- ☐ Racing Thoughts
- ☐ Hallucinations
- ☐ Rapid Speech
- ☐ Guilty Thoughts
- ☐ Paranoia
- ☐ Mood Swings
- ☐ Anxiety
- ☐ Risky Behavior

OTHER PROBLEMS:

_____

_____

_____

_____

_____

Patient Signature _____ Date: _____

Practitioner's Initials: _____