Name: _____ Referred by: _____

Birthdate (mm/dd/yyyy): ____/____/____ Primary Care Physician: _____

Occupation: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

PAST MEDICAL HISTORY: Please check all that apply, even if your medications have fixed the problem (examples: high blood pressure, high cholesterol, asthma, heart attack, depression, etc).

- ❑ High or low blood pressure
- ❑ Heart problems
- ❑ Pacemaker
- ❑ Angina
- ❑ Shortness of breath
- ❑ Asthma/sinus problems
- ❑ Lung problems
- ❑ Recent gain or loss of weight
- ❑ Liver disease
- ❑ Kidney/bladder problems
- ❑ Bowel problems
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Cancer
- ❑ Osteoporosis
- ❑ Headaches
- ❑ Stroke or head injury
- ❑ Depression
- ❑ Muscular disease
- ❑ Seizures, fainting or dizziness
- ❑ Fractures
- ❑ Bursitis/tendonitis
- ❑ Arthritis
- ❑ Neck/back pain
- ❑ Glasses or contacts
- ❑ Hearing loss
- ❑ Infectious disease
- ❑ Skin conditions
- ❑ Smoking history
- ❑ Other: _____

Have you fallen in the last 6 months? ❑ YES ❑ NO

Do you take any medication that causes you to feel dizzy or unsteady? ❑ YES ❑ NO

PAST SURGICAL HISTORY: Please ***list prior surgeries with approximate dates,*** no matter how long ago (examples: appendectomy, gall bladder removal, tonsillectomy, hip or knee surgery, etc).

OPERATION	YEAR	REASON
1.		
2.		
3.		
4.		
5.		

Do you have ALLERGIES to medication, food, latex, adhesives? ❑ Yes ❑ No If yes, please list:

Please list **CURRENT MEDICATIONS** with dosage (including aspirin, advil, and multivitamins)

1. 5.
2. 6.
3. 7.
4. 8.

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OUTPATIENT THERAPY HISTORY FORM

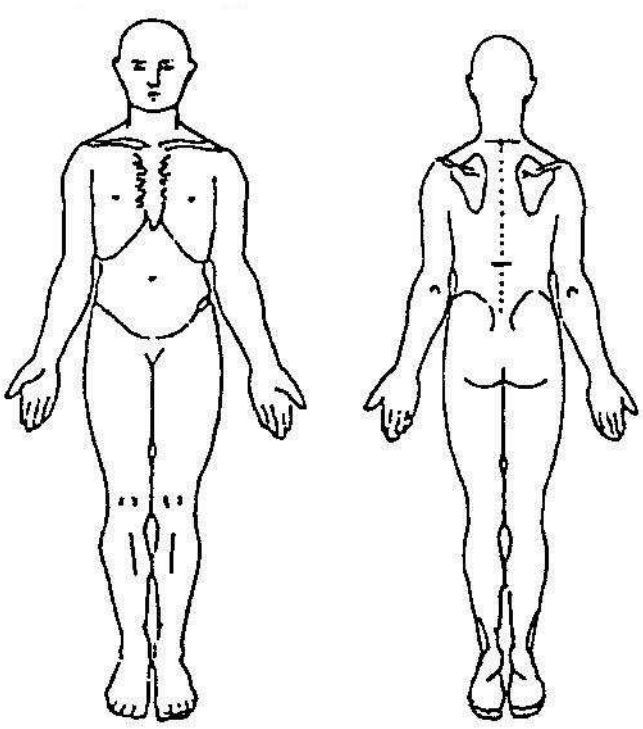
MOST RECENT HOSPITALIZATION DATES: _____

REASON(S) FOR HOSPITALIZATION: _____

_____

PREVIOUS THERAPY FOR CURRENT CONDITION:

Mark the location(s) of your pain with an "x" on the diagram. If whole areas are painful, shade in the painful area.
? Areas of numbness



Indicate your pain type by circling a letter or letters

A Deep (inside)
B Superficial (on the skin)
C Constant (all the time)
D Intermittent (starts & stops)
E Aching
F Burning
G Shooting
H Numbness
I Other

Please rate your pain by circling on the scale below, with "0" being no pain, and "10" being excruciating pain.

0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain?

What makes it better?

What makes it worse?

Current Symptoms (please check all that apply)

❑ Numbness or tingling	❑ Weakness/fatigue	❑ Chronic coughing
❑ Extremity swelling	❑ Loss of balance/falling	❑ Difficulty swallowing
❑ Cold extremities	❑ Coordination problems	❑ Hoarseness
❑ Blurred or double vision	❑ Sleeplessness	❑ Night sweats/chills/fever
❑ Memory loss	❑ Concentration problems	❑

I learn better by:	❑ Hearing	❑ Reading	❑ Pictures	❑ All

Form completed by: _____

Date: _____ Time: _____ Reviewed by: _____

Please tell your therapist of any new medical diagnosis, invasive procedures, allergies or medication changes during this treatment period.

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OUTPATIENT THERAPY HISTORY FORM