TRINITY
PHYSICAL THERAPY

HEALTH HISTORY FORM

Full Name: _____Nickname:_____

Primary complaint:_____

Describe your injury and/or cause of pain._____

_____Date pain began:_____

Were you involved in an automobile accident?___ Do you have an attorney?___ Attorney/Firm's name_____

Your pain at **best** on a scale of 0-10. **No pain <u>0</u>** 1 2 3 4 5 6 7 8 9 **<u>10</u> unbearable pain.** Please circle.

Your pain at **worst** on a scale of 0-10. **No pain <u>0</u>** 1 2 3 4 5 6 7 8 9 **<u>10</u> unbearable pain.** Please circle.

List ALL surgical procedures you have had and date of surgery (bone, joint, heart, etc.)_____

_____**Do you have a pacemaker?**_____

Have you ever been diagnosed with any of the following? ***Please circle.***

- Heart Attack
- Stroke
- Diabetes
- Cancer
- Asthma
- Osteoporosis
- Tuberculosis
- Epilepsy
- Sleep Apnea
- High Blood Pressure
- Emphysema
- Arthritis
- Chronic Heart Failure
- Thyroid Disorder
- Seizures
- Depression
- Anxiety

List any other conditions that are not listed above._____

Allergies:_____

Describe your exercise habits. _____

Are you mainly **extremely active**, **fairly active**, or **not active at all**? *Please circle one.* Do you smoke?_____

Do you live alone?_____Apartment_____One level home_____Home with stairs_____

What kind of work do you do?_____

Are you having pain in any area of your body other than what you are being seen for today? _____ If yes, please describe._____

****How did you hear about our clinic?**_____