

HEALTH INFORMATION FORM

Patient Name (please print): _____

Injury or reason for receiving therapy: _____

Surgery Required? Y N If yes, **Date & Type of Surgery:** _____

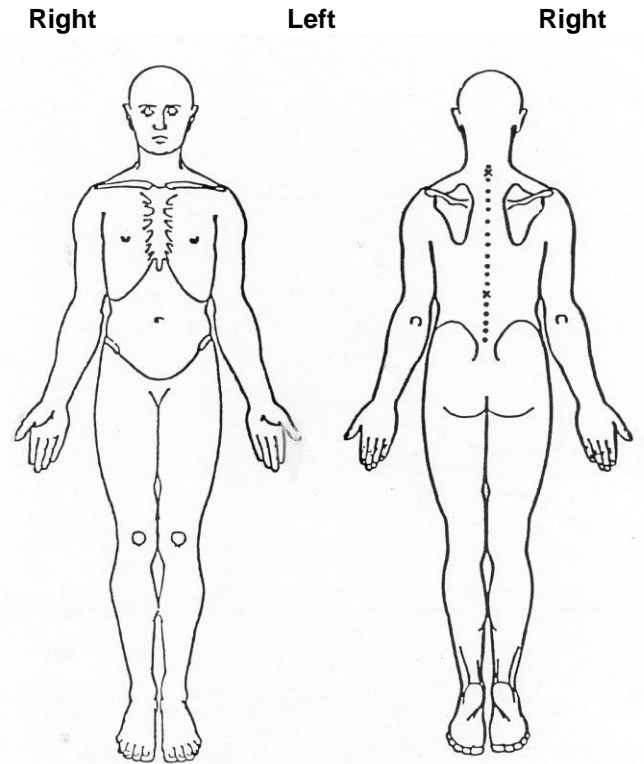
Personal Treatment Goals: (What do you want to accomplish with therapy?) _____

List current physical activities: _____

Conditions: (check all that apply) History of: Currently Applies: Currently Taking Meds for:

Allergies: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis: Osteo / Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder, Clotting or Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance Problems, Dizziness, or Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fractures (Broken Bones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head / Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disorders / Abnormal EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia: Hiatal / Inguinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence of Bowel or Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infections (Bladder, Ear etc...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphedema / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck or Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio or Post Polio Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking / Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach / Intestinal Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trauma / Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual / Hearing Impairments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss / Gain: _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark location of injury or affected area(s)



Current Pain level: (circle one)

0 1 2 3 4 5 6 7 8 9 10
No pain Max pain

Pain Description: (check all that apply)

- | | | |
|---------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Sharp | <input type="checkbox"/> Day time |
| <input type="checkbox"/> Intermittent | <input type="checkbox"/> Dull | <input type="checkbox"/> Night time |
| | <input type="checkbox"/> Achy | |

Medication or Supplements (please list any that you are taking) : _____

Signature: _____ Date: _____