BENTZ PHYSICAL THERAPY HEALTH HISTORY FORM

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

Is anyone currently coming to your home to provide you care? □ Yes □ No Who? _____

Please describe the problem/symptoms you are currently experiencing: _____

_____

_____

When did your symptom being? _____ How did your symptoms begin? _____

_____

Overall are your symptoms? □ Getting Better □ Staying the same □ Getting Worse

What makes your symptoms WORSE? _____

What makes you symptoms BETTER? _____

How often do you experience your symptoms? □ Constant □ Frequent □ Occasional □ Intermittent

Have you had any of the following: □ Physical Therapy □ Imaging (X-ray, MRI, CT scan) □ Injections

□ Medication □ Hospitalization □ Surgery □ Other _____

Do you have a follow up appointment with your referring doctor? □ Yes □ No Date: _____

Have you ever had any of the following conditions or diagnoses? Check all that apply.

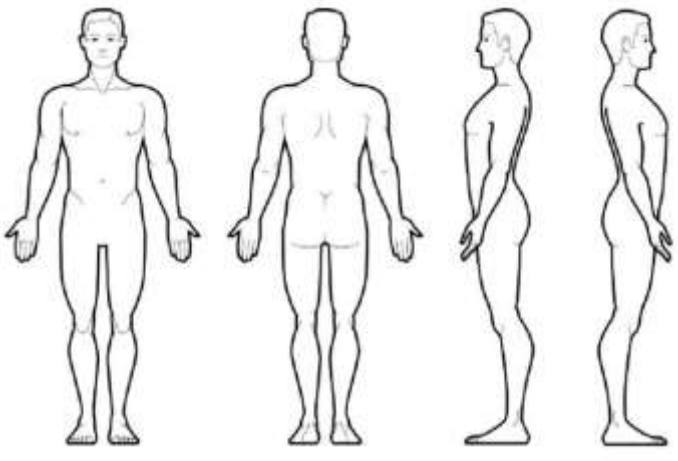
□ Alcoholism / Drug Use
□ Allergies _____
□ Anemia
□ Asthma
□ Auto Immune Disorder
□ Bone Fracture
□ Bowel or Bladder Difficulty
□ Cancer _____
□ Chronic Fatigue Syndrome
□ Depression
□ Diabetes
□ Dizziness
□ Eating Disorder
□ Fibromyalgia
□ Headaches
□ Hearing Loss
□ Heart Disease
□ Hepatitis
□ High Blood Pressure
□ HIV / AIDS
□ Irritable Bowel Syndrome
□ Joint Replacement _____
□ Kidney Disease
□ Low Back Pain
□ Multiple Sclerosis
□ Osteoarthritis
□ Osteoporosis
□ Pacemaker
□ Pregnant (□ Now □ Recent)
□ Psychiatric Disorder
□ Rheumatoid Arthritis
□ Sacroiliac/Tailbone Pain
□ Seizures
□ Smoking History
□ Stroke
□ Thyroid Disease
□ Vision/Eye Problems
□ Other _____

Surgical History _____

_____

_____

Mark all area(s) where you are experiencing symptoms with the appropriate symbol.



Aching	******
Numbness	======
Pins and Needles	++++++
Burning	xxxxxx
Stabbing	//////

Please rate your pain:

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe