



CPT Colleyville Physical Therapy

 & Sports Rehab

PATIENT HEALTH HISTORY

Patient Name: _____ Primary Care Physician: _____

1. Reason for visit: _____
- a. When did your symptoms start?: _____
- b. How did your symptoms begin?: _____

2. Please check if you have ever been treated for any of the following health conditions and the date when it occurred (or date diagnosed):

	<u>Date(s)</u>		<u>Date(s)</u>
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Fractures	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Liver Disease	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Ulcers	_____	<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Migraine	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Car accident	_____
<input type="checkbox"/> Pacemaker	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Other _____	_____

3. How much of the time does your condition interfere with your social activities: Not at all A little of the time Some of the time Most of the time All of the time

a. What activities: _____

4. Who have you seen for your symptoms? No One Medical Doctor Chiropractor Physical Therapist
 Other: _____

a. What tests have you had for your symptoms and when?

<input type="checkbox"/> Xrays	Date: _____
<input type="checkbox"/> CT Scan	Date: _____
<input type="checkbox"/> MRI	Date: _____
<input type="checkbox"/> Other: _____	Date: _____

5. Have you had similar symptoms in the past? Yes No

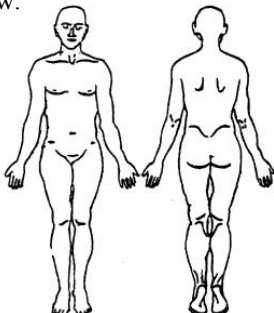
a. If yes, who did you see? This clinic Medical Doctor Chiropractor Other Physical Therapist
 Other: _____

6. Please list any past surgeries with dates:

7. Please list any medications you are currently taking:

8. What is your desired outcome from physical therapy: _____

9. Please indicate your location of pain on the diagram below:



10. Please indicate where your pain level is on the line below (0=none, 10=emergency room pain):



11. Do you participate in any exercise programs, or activities on a regular basis? _____
