

# VALLEY REHABILITATION, LTD.

## PHYSICAL THERAPY

### PATIENT HEALTH HISTORY

Name \_\_\_\_\_

Why are you being seen in our office today?  
\_\_\_\_\_

How long ago did the problem start? \_\_\_\_\_

Check the box that best describes how your problem began.

Illness, (*no injury*),  gradual or  sudden onset. Why do you think it started? \_\_\_\_\_

Injury ( Accident  Sport *\*Not auto or work*) Date \_\_\_\_\_

Injury at work. Date : \_\_\_\_\_ From a  lift  twist  fall  bend  pull  reach

Work related but no injury. Date: \_\_\_\_\_ How did your job cause the problem? \_\_\_\_\_

Auto Accident. Date: \_\_\_\_\_

Any additional  
comments \_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

What is your most painful activity? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

What would you like to be able to do that you can no longer do?  
\_\_\_\_\_

### **Acknowledgment of receipt of notice of privacy practices.**

I acknowledge that a copy of Valley Rehabilitation's Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Valley Rehabilitation's privacy practices or my rights with regard to my personal health information (PHI), I may contact Valley Rehabilitation's Privacy Officer for further information as set forth in the Notice.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by patient's personal representative, state representative's relationship to patient and authority to act on behalf of patient. \_\_\_\_\_

Witness for Valley Rehabilitation \_\_\_\_\_ Date \_\_\_\_\_

To insure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you.

Name \_\_\_\_\_ Leisure activities \_\_\_\_\_ Occupation \_\_\_\_\_

Allergies: Please list any medications you are allergic to: \_\_\_\_\_

Are you latex sensitive? YES NO List any other allergies we should know about \_\_\_\_\_

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? YES NO

Please check ( ) any of the following whose care you are under:

\_\_ Medical Doctor \_\_ Psychiatrist/Psychologist \_\_ Osteopath \_\_ Dentist \_\_ Chiropractor \_\_ Physical Therapist

Date of last physical examination \_\_\_\_\_

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): \_\_\_\_\_

Have you ever been diagnosed as having any of the following conditions?

YES NO Cancer. If YES what kind: \_\_\_\_\_

YES NO Do you have a Pacemaker?

YES NO Heart Problems. If YES what kind \_\_\_\_\_

YES NO High blood pressure

YES NO Circulation problems

YES NO Asthma

YES NO Stomach ulcers

YES NO Chemical dependency (i.e. alcoholism)

YES NO Thyroid problems

YES NO Diabetes

YES NO Multiple sclerosis

YES NO Rheumatoid arthritis

YES NO Other arthritic conditions

YES NO Depression

YES NO Hepatitis

YES NO Tuberculosis

YES NO Stroke

YES NO Kidney disease. If YES what kind \_\_\_\_\_

YES NO Blood Clots

YES NO Osteoporosis

YES NO Other \_\_\_\_\_

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things?

YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

SURGERIES/HOSPITALIZATIONS INCLUDE DATE AND REASON

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_ (over to page 2)

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains)

Date	Injury	Date	Injury
_____	_____	_____	_____

Has anyone ***in your immediate family*** (parents, brothers, sisters) ever been treated for any of the following?

- |                               |   |
|-------------------------------|---|
| YES NO Diabetes               | YES NO Cancer                           |
| YES NO Heart disease          | YES NO Alcoholism (chemical dependency) |
| YES NO High blood pressure    | YES NO Depression                       |
| YES NO Stroke                 | YES NO Suicide                          |
| YES NO Inflammatory Arthritis |   |

Which of the following medications have you taken in the last week?

	Physician prescribed	Not prescribed by Physician
Aspirin	YES NO	YES NO
Tylenol	YES NO	YES NO
Anti-Inflammatories (Advil/Motrin/etc)	YES NO	YES NO
Stomach Ulcer Medications	YES NO	YES NO
Vitamins/mineral supplements	YES NO	YES NO
Herbals/Remedies	YES NO	YES NO

Others NOT prescribed by a physician \_\_\_\_\_

Please list any other physician-prescribed medication you are currently taking (including pills, injections, and/or skin patches):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

How much caffeinated coffee or beverages containing caffeine do you drink per day? \_\_\_\_\_

Tobacco Use: How many packs do you smoke per day \_\_\_\_ for how many years \_\_\_\_ + If quit when? \_\_\_\_

How many days per week do you drink alcohol? \_\_\_\_\_

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? \_\_\_\_\_

**Please circle any of the following that are NEW, UNUSUAL, or ATYPICAL for you**

- |  |                                   |
|--|-----------------------------------|
| YES NO weight loss/gain                  | YES NO joint/muscle swelling      |
| YES NO nausea/vomiting                   | YES NO easy bruising              |
| YES NO fatigue                           | YES NO excessive bleeding         |
| YES NO weakness                          | YES NO difficulty breathing       |
| YES NO fever/chills/sweats               | YES NO regular cough              |
| YES NO dizziness/lightheadedness         | YES NO tremors                    |
| YES NO arm/leg swelling                  | YES NO heart racing in your chest |
| YES NO numbness or tingling              | YES NO seizures                   |
| YES NO heartburn/indigestion             | YES NO double vision              |
| YES NO constipation/diarrhea             | YES NO loss of vision             |
| YES NO blood in stools                   | YES NO eye redness                |
| YES NO post menopause                    | YES NO skin rash                  |
| YES NO problems urinating/pain, starting | YES NO problems sleeping          |
| YES NO urinary incontinence              | YES NO sexual difficulties        |
| YES NO blood in the urine                | YES NO night sweats               |
| YES NO pregnant or think you might be    | YES NO hearing problems           |
| YES NO stress at home or at work         |                                   |

_____	_____	_____	_____
Patient Signature	Date	Therapist Signature	Date