Osteopractic Physical Therapy Carolinas

Patient Health Information

Name:	Date:	DOB:

Have you ever been diagnosed with any of the following? If "Yes", please explain in the space provided.

DISEASE PROCESSES:

Cancer	NO	YES	
Diabetes Mellitus	NO	YES	
High Blood Pressure	NO	YES	
Arthritis	NO	YES	
Osteoporosis	NO	YES	
Seizures	NO	YES	
Coronary Artery Disease	NO	YES	
Atherosclerosis	NO	YES	
Heart or Vascular Diseases	NO	YES	

CURRENT HEALTH / MEDICAL CONDITIONS:

Do you have chest pain?	NO	YES	
Have you ever had a stroke(s)?	NO	YES	
Do you have a Pacemaker?	NO	YES	
Do you have breathing problems	NO	YES	
Do you have frequent headaches/migraines?	NO	YES	
Unexplained nausea or vomiting?	NO	YES	
Unexplained fever, night sweats?	NO	YES	
Do you routinely have pain while sleeping?	NO	YES	
Unexplained weight loss?	NO	YES	
Changes in bowel or bladder function?	NO	YES	
Dizziness/Vertigo?	NO	YES	
Numbness & Tingling in face or groin area?	NO	YES	
Sudden changes in vision?	NO	YES	
Difficulty swallowing?	NO	YES	
Unexplained blackouts?	NO	YES	
Urinary tract infection less than 1 month ago?	NO	YES	
Are you currently pregnant?	NO	YES	

SOCIAL HISTORY:

Do you smoke?	NO	YES	
Have you recently suffered trauma from a fall, car accident, sports etc.?	NO	YES	

Do you have problems with the following?

Hearing?	NO	YES	Communication?	NO	YES
Speech?	NO	YES	Reading?	NO	YES
Vision?	NO	YES	Writing?	NO	YES

Please list your surgical history, including dates (if any): ______________________________

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Medications you are currently taking (if any): ______________________________

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Physical Therapy
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INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

KEY

/// Stabbing	XXX Burning	000 Pins and Needles	= = = Numbness	ZZZ Aching