Adult History Form

Name_________________________________ Date_____________

Chief Complaint/Reason for Visit_______________________________________________________________

Medical or functional diagnosis? ______________________________________________________________

Emergency Contact: ___________________________________ Phone:______________________________

Please add me to your newsletter list so that I can receive information on upcoming programs and education opportunities. □ Yes □ No Email: ________________________________

How did you hear about us? □ Newspaper □ Magazine □ Another client/friend □ Flyer □ Website □ Radio □ TV
□ medical provider referral □ Yellow Pages □ Other:____________________________________________

Does you have a County Case Manager? □ Yes □ No Name: _______________________________________

Did problem result from an injury? □ Yes □ No Date/Type of Injury_______________________________

Previous Surgeries/Dates...................................................................................................................

Previous Treatment for Problem: ......................................................................................................

Have you been given restrictions by your physician? □ Yes □ No Describe____________________________

Are you currently under the care of another physical therapist? □ Yes □ No □ Dismissed

Are you getting any home care services? What are they? _________________________________________

Describe things that make your symptoms better........................................................................

Describe things that make your symptoms worse........................................................................

Overall, my symptoms are □ getting better □ getting worse □ staying the same

Describe your current level of exercise............................................................................................

Rate your CURRENT pain:

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Extreme Pain

Location of Pain___________________________ Is it? □ Constant □ Fluctuating □ Other ______________

Please rate your overall health □ Excellent □ Very Good □ Good □ Fair □ Poor
Please mark any of the following conditions you have had:

- [ ] AIDS/HIV
- [ ] Cancer
- [ ] Lung Problems
- [ ] Infectious Disease
- [ ] Allergies
- [ ] Stroke
- [ ] Vision Loss
- [ ] Liver Problems
- [ ] Anemia
- [ ] Chemical Dependency
- [ ] Hearing Loss
- [ ] Musculoskeletal Condition
- [ ] Arthritis
- [ ] Circulation Problems
- [ ] Heart Attack
- [ ] Neurologic Condition
- [ ] Asthma
- [ ] Depression
- [ ] Heart Disease
- [ ] Pacemaker
- [ ] Blood Clots
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Pregnancy (Current)
- [ ] Brain Injury
- [ ] Low Blood Pressure
- [ ] Infection
- [ ] Spinal Cord Injury