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