DORSET PHYSIO 3155 RT-30 Dorset, VT 05251 Phone 802-867-7056 Fax 802-440-0280

PATIENT HEALTH HISTORY FORM

TODAY'S DATE _____

Name_____ **Age**_____ **D.O.B.** _____
Preferred Pronoun: She/her/hers He/him/his They/them/theirs
Employer_____ **Date of Injury/Onset of Pain**_____

Referring Physician_____ **Next appointment with referring physician**_____
Chief Complaint: What is the nature of your pain or problem? _____
_____
_____

Have you seen any other health professional(s) for this or any other condition? YES NO
If yes, who? _____ **Approximately how many times this year?** _____
Injury work related? YES NO Injury motor vehicle related? YES NO If yes, are you currently working with an Attorney for this? YES NO Name and Address of Attorney_____

Please list all Medications here (or we are happy to make a photocopy of your list at your appointment):
_____
_____

Are you allergic to LATEX? YES NO Any other allergies? _____

Do you now have, or have you had, any of the following?

Heart Disease/Attack	**YES NO**	**Diabetes**	**YES NO**
Cancer	**YES NO**	**Seizures**	**YES NO**
Pregnant (currently)	**YES NO**	**High Blood Pressure**	**YES NO**
Dizziness	**YES NO**	**Osteoporosis**	**YES NO**
Stroke	**YES NO**	**Asthma/COPD**	**YES NO**
Chronic Headaches	**YES NO**	**Arthritis/Joint Pain**	**YES NO**
Tooth/Jaw/Ear Pain	**YES NO**	**Previous Physical Therapy**	**YES NO**
Past Surgeries	**YES NO**	**Other Health Issues**	**YES NO**

If you answered YES to any of the above, please explain and give approximate dates and/or details:
_____
_____

Have you had any of the following? ▢**MRI** ▢ **X-Ray** ▢**CT Scan If yes, where?** _____
_____

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Please indicate on the pictures to the right the locations of your pain. *(if applicable)*

Please indicate your level of pain at its WORST and BEST on the left.

0=NO PAIN 10=EXCRUCIATING PAIN

CURRENT: 0 1 2 3 4 5 6 7 8 9 10

BEST: 0 1 2 3 4 5 6 7 8 9 10

WORST: 0 1 2 3 4 5 6 7 8 9 10

TIME OF DAY PAIN IS WORSE (circle one):

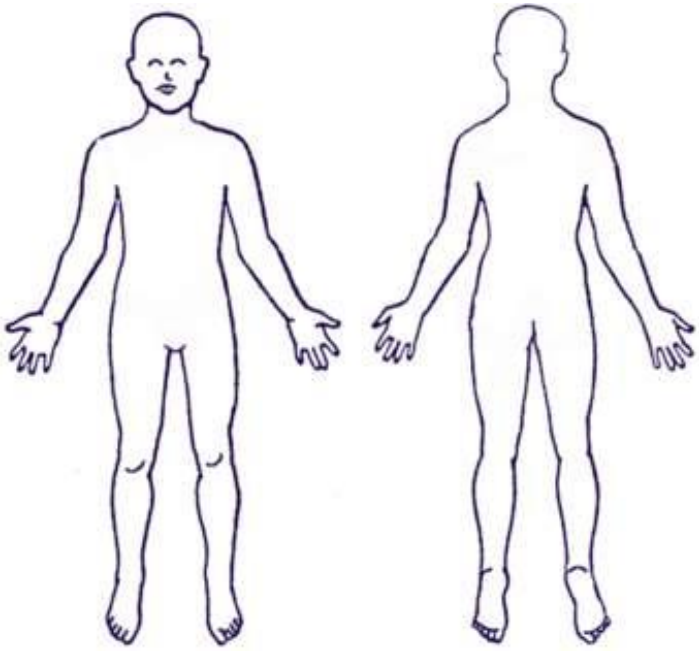
MORNING AFTERNOON NIGHT

INTERMITTENT CONSTANT

TIME OF DAY PAIN IS BEST (circle one):

MORNING AFTERNOON NIGHT

INTERMITTENT CONSTANT



Do you use any Assistive Device/Equipment (circle all that apply): Cane Walker Crutches Walking Poles Wheelchair Brace/Splint Lift Chair Shower Chair Bedside Commode

If you are 65 and over OR have sustained a fall please answer these questions:
Have you had any falls in the past 6 months?*(circle one)* **YES NO How many:_____**
Any fall(s) that resulted in injury?*(circle one)* **YES NO**
If answered YES to anything above, please describe:

_____

Is there anything else you feel we should know to assist in your treatment?

_____

Please List 3 goals you have for Physical Therapy:

1. _____
2. _____
3. _____

The information above is accurate to the best of my knowledge.
Patient Signature: _____ Date: _____