Personal Wellness and Physical Therapy by dr Bo, DPT

Medical History Intake Form

Name:_____Age/ DOB:_____

Email address _____ Cell Phone :_____

Are you currently experiencing or have you had any of the following :

High Blood Pressure	**Y N**	**Heart Disease**	**Y N**	**Numbness**	**Y N**
Bowel/ Bladder Problems	**Y N**	**Pacemaker**	**Y N**	**Cancer**	**Y N**
Shortness of Breath	**Y N**	**Weakness**	**Y N**	**Pregnant**	**Y N**
Female Problems	**Y N**	**Diabetis**	**Y N**	**Dizziness**	**Y N**
NIght Pain	**Y N**	**Fatigue**	**Y N**	**Osteoporosis**	**Y N**
Irregular Heart Rate	**Y N**	**Headache**	**Y N**	**Stroke**	**Y N**

Have you had any steroids/ anti-inflammatory or epidural injections during last month? Y or N

If yes , where and when?_____

Are you taking any photosensitizing medication? Y N Can you be in the sun, at least 10 min: Y N

Surgeries: Y N (LIST):_____

How would you rate your general health? (circle one) Poor Fair Good Excellent

In the past 3 months, have you experienced any changes in health (physical or mental) such as unexplained Weight loss, depression, nausea, etc, (List) _____

List other medical problems:_____

Currently:

What is your current complaint?_____ When did it start ? Y N

Due to an injury ? Y N (Explain) _____Ilness? Y N

Previous Therapy for this condition? Y N What affect? _____

Have you had any other treatment for this condition ? Y N PT ? Chiro ? Pain Management ?

Are you getting: Better Same Worse Are you getting better with rest ? Y N

Does activity make it worse ? Y N Which activity and where?_____

Are you worse in the : Morning Afternoon Evening . Is your pain: Continues? Or Occasional ?

What makes your pain better? _____

What makes your pain worse? _____

Does your pain radiate somewhere? Y N Where? _____

What can't you do because of your pain/dysfunction ?_____

List all recent tests? X-rays? MRI ? CT ? Myelogram? Nerve conduction test? Other?

Results? _____

Do you have an official diagnosis from your doctor? _____

If yes, did your doctor restrict your activities? How ? _____

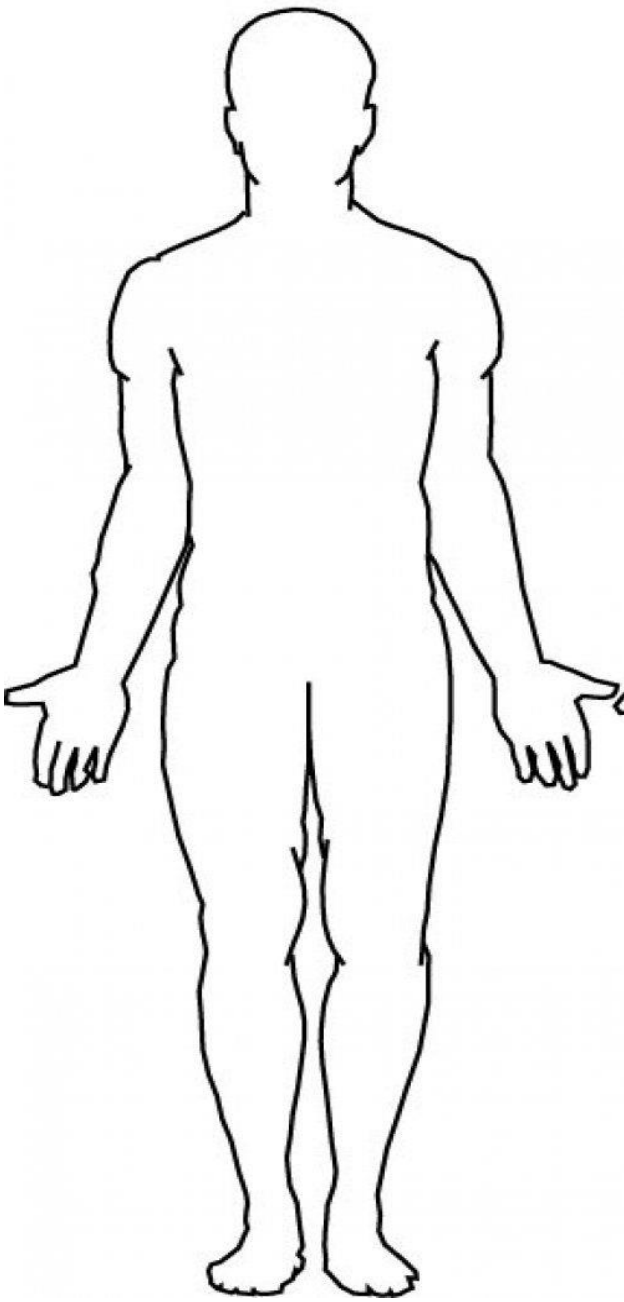
Are you employed? Y N What activities you do at your job? _____

Are you currently in pain ? Y N What is the level of your pain ? 0 - none to 10 max ? _____

Pain at this moment ? _____Highest in the last 24 hrs? _____ Lowest in the last 24hrs?_____

Use the diagram on the other side to mark the area of your pain for front and back, right and left:

L FRONT R



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