HEAD TO TOE PHYSICAL THERAPY

PATIENT HEALTH INFORMATION

Name:_____ Occupation:_____ Age:____
Date of Onset: Pain/Injury/Surgery:_____
Briefly state previous treatment, if any: _____
_____

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

DIABETES	YES__NO__	ALLERGY TO COLD	YES__NO__
HIGH BLOOD PRESSURE	YES__NO__	OTHER ALLERGIES	YES__NO__
PACEMAKER	YES__NO__	PREVIOUS SURGERY	YES__NO__
CHRONIC HEADACHES	YES__NO__	SIEZURES	YES__NO__
KIDNEY PROBLEMS	YES__NO__	METAL IMPLANTS	YES__NO__
ANXIETY/DEPRESSION	YES__NO__	DIZZINESS	YES__NO__
HERNIA	YES__NO__	CANCER	YES__NO__
ALLERGY TO HEAT	YES__NO__	CURRENTLY PREGNANT	YES__NO__
BONE DISEASE	YES__NO__	OSTEOPOROSIS	YES__NO__
FRACTURES	YES__NO__	BOWEL PROBLEMS	YES__NO__
BLADDER PROBLEMS	YES__NO__	RECENT WEIGHT LOSS	YES__NO__
PINS/NEEDLES FEELING	YES__NO__	CIRCULATORY DISEASE	YES__NO__
PROBLEM WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME			YES__NO__

If YES to any of the above, please explain and give appropriate details:_____
_____
_____
_____

Are you presently taking any medications? YES__NO__

If YES, please list your medications and for what condition: _____
_____
_____
_____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic tests for your recent pain/injury/condition? YES__NO__ If YES, please explain the findings as you understand them:
_____
_____
_____

Is there anything else you think I should know about your general health, or current condition? Please explain and, if necessary, we can talk about it:_____
_____
_____