ABILITY PHYSICAL THERAPY

PATIENT HISTORY FORM

CLINIC: LAFAYETTE

Patient Name: _____ Date: _____

E-mail Address: _____ D.O.B. _____

Height: _____ Weight: _____

MEDICAL HISTORY Do you have/had any of the following medical conditions?

	YES	NO		YES	NO
HEART PROBLEMS?	____	____	PACEMAKER?	____	____
HIGH BLOOD PRESSURE?	____	____	DIABETES?	____	____
TB/HIV/HEPATITIS?	____	____	CANCER?	____	____
SEIZURES?	____	____	PREGNANT?	____	____
URINARY INCONTINENCE?	____	____	OSTEOPOROSIS?	____	____

PLEASE DESCRIBE **ANY** OTHER HEALTH ISSUES: _____

_____

List **MEDICATIONS** you are currently taking? How often? What amount?_____

_____

List any **ALLERGIES**:_____

Describe your current physical complaint (When did it occur? How did it happen?): _____

_____

Have you received Therapy for this problem/injury? YES _____ NO _____ If yes, was it helpful?_____

_____

List other surgeries, injuries, or medical problems you have had in the past 5 years?

_____

_____

_____

Has your current situation caused any significant difficulty within your family/social life? YES _____ NO _____
PLEASE DESCRIBE: _____

_____

What goals would you like to achieve in Therapy? _____

What activities have you had difficulty doing since your injury/illness?

_____

_____

WORK INFORMATION

Who is your employer? _____ What is your occupation? _____
Do you want assistance communicating with your employer? ☐ YES ☐ NO
What is your present work status? ***Please mark only one***
☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Working ☐ Unemployed
Describe the physical requirements of your job. (Please indicate amount of weight you lift, amount of time spent standing/sitting/walking.)_____

_____

_____