Mend Physical Therapy

Date:
Reviewers Initials:

Health History

First Name Middle Initial Last Name

Street Address, City, State, Zip Code

Primary Phone Number Email

Referring Physician/Primary Care Physician Phone

Emergency Contact, Name Phone

Are you employed?___y___n__ Current Occupation:_____

Right/ Left Handed (circle) Date of Birth:_____

Briefly describe the history of the problem: _____

Was the problem sudden/gradual? _____Date of onset?_____
Where is your pain:_____
What type of pain are you having? □ Dull □ Achy □ Tingling □ Shooting □ Stabbing □ Burning □ Other _____
Current Pain level:_____ /10 (10 being pain that would render you hospitalized)

What imaging have you had? _____When/what was found?_____

Have you had previous treatment? If so what type (PT, DC, LMT)

What makes your pain worse? _____

What makes your pain better? _____

List one activity you would like to be able to do with less pain (what is your goal)?

Please list prescription medication you are taking:

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Circle if you have had any of the following recently:

Numbness/Pins and Needles
Fever/Chills/Sweats
Weakness/Fatigue
Headaches
Unexpected weight loss/gain
Changes in bowel or bladder
Pain waking you at night
Shortness of Breath
Vision Problems

Circle if you have a history any of the following:

Osteoporosis
Lung Problems
Rheumatoid Arthritis
Anemia
Multiple Sclerosis
Parkinson's Disease
Surgery (Please list)
Cancer (type) _____
High Blood Pressure
Stroke
Thyroid Problems
Kidney Problems
Hepatitis
Other_____
Heart Problems
Pacemaker
Depression
Diabetes
Epilepsy
Tuberculosis
Other_____

What else is important to you that will impact your treatment, what did we miss above?

_____

_____

_____

Signature