Physical Therapy Works
MANUAL THERAPY EXPERTS

3407 South 84th Street
Omaha, NE 68124
(402)614-8042

PATIENT HEALTH HISTORY

Name:_____

Have you ever been diagnosed as having any of the following conditions?

❍No ❍Yes Cancer (if so, what type?_____ _____
❍No ❍Yes Asthma
❍No ❍Yes Diabetes
❍No ❍Yes Depression
❍No ❍Yes Kidney Disease
❍No ❍Yes Osteopenia/Osteoporosis
❍No ❍Yes Heart problems
❍No ❍Yes Emphysema/Bronchitis
❍No ❍Yes Multiple Sclerosis
❍No ❍Yes Hepatitis
❍No ❍Yes Anemia
❍No ❍Yes High blood pressure
❍No ❍Yes Chemical dependency(i.e. alcoholism)
❍No ❍Yes Rheumatoid arthritis
❍No ❍Yes Tuberculosis
❍No ❍Yes Epilepsy
❍No ❍Yes Stroke
❍No ❍Yes Circulation problems
❍No ❍Yes Thyroid problems
❍No ❍Yes Other arthritic conditions
❍No ❍Yes Incontinence
❍No ❍Yes Other_____

At the present time, would you say your health is ❍Excellent ❍Very Good ❍Fair ❍Poor

Have you ever had an allergic reaction to: ❍Lotion ❍Perfume ❍Gel ❍Latex ❍Adhesives?

During the past month have you been feeling down, depressed or hopeless? ❍No ❍Yes

During the past month have you been bothered by having little interest or pleasure in doing things? ❍No ❍Yes

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ❍No ❍Yes

Has anyone in your immediate family (parents, brothers, sisters) been treated for any of the following?

❍No ❍Yes Diabetes
❍No ❍Yes Heart Disease
❍No ❍Yes Stroke
❍No ❍Yes Alcoholism (chemical dependency)
❍No ❍Yes Arthritis
❍No ❍Yes Headaches
❍No ❍Yes Mental illness
❍No ❍Yes Tuberculosis
❍No ❍Yes High blood pressure
❍No ❍Yes Kidney disease
❍No ❍Yes Cancer
❍No ❍Yes Anemia
❍No ❍Yes Epilepsy
❍No ❍Yes Other_____

Which of the follow over-the-counter medications have you taken in the last week?

❍No ❍Yes Aspirin
❍No ❍Yes Advil/Motrin/lbuprofen
❍No ❍Yes Decongestants
❍No ❍Yes Antacid
❍No ❍Yes Other _____ _
❍No ❍Yes Tylenol
❍No ❍Yes Laxatives
❍No ❍Yes Antihistamines
❍No ❍Yes Vitamins/mineral supplements

How much caffeinated or caffeine containing beverages do you drink per day? _____ _
How many packs of cigarettes do you smoke a day? _____ __ _
How many days per week do you drink alcohol? _____ _
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted:

❍No ❍Yes Weight loss/gain
❍No ❍Yes Dizziness/lightheadedness
❍No ❍Yes Weakness
❍No ❍Yes Numbness or Tingling
❍No ❍Yes Nausea/Vomiting
❍No ❍Yes Fatigue
❍No ❍Yes Fever/chills/sweat
❍No ❍Yes Bowel or Bladder leakage

_____ _____

Therapist signature **date** **Patient Signature** **date**