FYZICAL®
Therapy & Balance Centers

ADULT PATIENT HISTORY

Name: _____ **Date:** _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____

Are you latex sensitive: YES ____ No _____ Do you smoke? Yes _____ No _____

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the follow (check all that apply)?

- ☐ Changes in your health
- ☐ Weight loss/gain
- ☐ Falls
- ☐ Nausea/vomiting
- ☐ Shortness of breath
- ☐ Pain at night
- ☐ Dizziness/lightheadedness
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness or tingling
- ☐ Changes in appetite
- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Difficulty maintaining balance while walking
- ☐ Constipation
- ☐ Changes in bowel or bladder function
- ☐ Difficulty swallowing
- ☐ Diarrhea

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Rheumatoid arthritis
- ☐ Diabetes
- ☐ Heart problems
- ☐ Other arthritic condition
- ☐ Stroke
- ☐ High blood pressure
- ☐ Depression
- ☐ Blood clots
- ☐ Circulation problems
- ☐ Asthma
- ☐ Anemia
- ☐ Lung problems
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Multiple sclerosis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Chest pain/angina
- ☐ Osteoporosis
- ☐ Liver problems
- ☐ Sexually transmitted disease/HIV
- ☐ Pacemaker inserted
- ☐ Other _____
- ☐ High cholesterol/lipids
- ☐ Chemical dependency (i.e., alcoholism)

During the past month have you been feeling down, depressed or hopeless? YES _____ NO_____

During the past month have you experienced little interest or pleasure in doing things? YES___ NO_____

Is this something with which you would like help? YES _____ YES, BUT NOT TODAY_____ NO_____

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES_____ NO _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES _____ NO_____

Please list current medications: _____

_____

Are you now or have you ever taken blood thinning or anticoagulants: YES _____ NO_____

Please list any surgeries or other conditions for which you have been hospitalized:

1._____ 2. _____ 3. _____

What date (roughly) did your present symptom(s) start? _____

What do you think caused your symptom(s)? _____

My symptoms are currently: Getting Better_____ Getting Worse _____ Staying about the same_____

Treatment received so far for this problem (chiropractic, injections, etc) _____

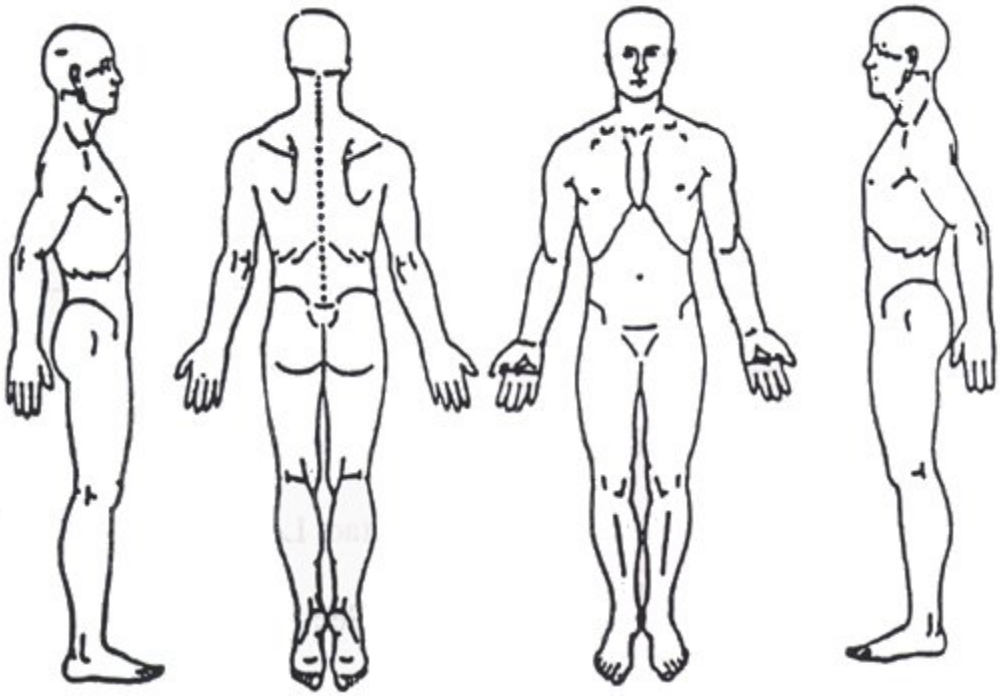
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ____ Yes ____ No When _____Treatment received _____

How long did it take for you to feel better? _____

*****PLEASE COMPLETE THE BACK OF THIS FORM*****

Please mark the areas where you feel your symptoms with the following symbols:



III Numbness = Tingling ↓ Shooting/sharp pain O Dull/ache pain

My symptoms currently: Come and go _____ Are Constant _____ Are constant, but change with activity _____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you sleeping at night?

Difficulty getting to sleep____ Awakened by pain____ Sleep only with medication____ Sleep through the night well_____

When are your symptoms worst? Morning ____ Afternoon ____ Evening ____ Night ____ After exercise_____

When are your symptoms the best? Morning ____ Afternoon ____ Evening ____ Night ____ After exercise_____

On the scale below, please circle the number which best represents your levels of pain:

Average:	No pain	0	1	2	3	4	5	6	7	8	9	10 Worst pain imaginable
Best for past 48 hours:	No pain	0	1	2	3	4	5	6	7	8	9	10 Worst pain imaginable
Worse for past 48 hours:	No pain	0	1	2	3	4	5	6	7	8	9	10 Worst pain imaginable

What is your goal for therapy at this time? _____

_____

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