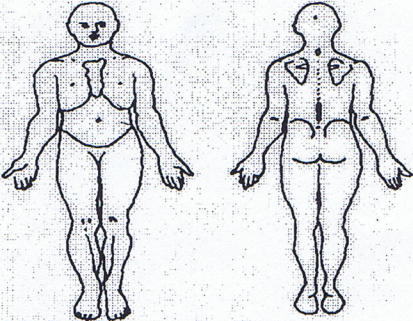


# ATP Physical Therapy Health History

Today's Date \_\_\_\_\_ Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for today's visit/Chief Complaint: \_\_\_\_\_

**PRESENT INJURY/CONDITION**

How did symptoms start?  What makes symptoms worse?  What makes symptoms better?  How would you rate your symptoms? MILD    MODERATE    SEVERE	<p><b><u>Please indicate area(s) of symptom on diagram:</u></b></p> Label: (P) Pain  (N) Numbness	
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**Past Medical History:** Please indicate (Y) Yes or (N) No if you have had any of the following health concerns.

High Blood Pressure	Y	N		Diabetes	Y	N	
Heart Trouble	Y	N	_____	Stroke	Y	N	_____
Chest Pain	Y	N	_____	Tuberculosis	Y	N	_____
Heart Murmur	Y	N	_____	Cancer	Y	N	_____
Respiratory Issues	Y	N	_____	HIV	Y	N	_____
Weakness of Muscles	Y	N	_____	Osteoporosis	Y	N	_____
Joint Pain/Stiffness	Y	N	_____	Tremors	Y	N	_____
Numbness/Tingling	Y	N	_____	Head Injury	Y	N	_____
Cold Extremities	Y	N	_____	Convulsions/Seizures	Y	N	_____
Bleeding Problems	Y	N	_____				
Other	Y	N	_____				

**Previous Hospitalization/Surgeries/Serious Illness** \_\_\_\_\_ **When?** \_\_\_\_\_

**Medication (include nonprescription)**

ARE YOU ALLERGIC TO LATEX? YES    NO

**FEMALE PATIENTS ONLY**      Are you pregnant?    Yes    Due date \_\_\_\_\_    No

Childbirth Information (Dates and Types of delivery (vaginal or C section))

**Patient Social History:**

Marital Status:    Single: \_\_\_\_\_    Married: \_\_\_\_\_    Separated: \_\_\_\_\_    Divorced: \_\_\_\_\_    Widowed: \_\_\_\_\_  
 Alcohol Use        Never: \_\_\_\_\_    Rarely: \_\_\_\_\_    Moderate: \_\_\_\_\_    Daily: \_\_\_\_\_    How Much? \_\_\_\_\_  
 Tobacco Use:      Never: \_\_\_\_\_    Previously, but quit.(when) \_\_\_\_\_    Current Packs/day: \_\_\_\_\_  
 Drug Use            Never: \_\_\_\_\_    Previously, but quit.(when) \_\_\_\_\_    Current use: \_\_\_\_\_    Type? \_\_\_\_\_

**\*\*\* TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS CORRECT AND ACCURATE.\*\***

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_  
Date: