Integrated Physical Therapy, Inc.

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PHYSICAL THERAPY HEALTH & HISTORY

Name: _____ Date: _____ SS#:_____ Home Phone:_____

Birth date:_____ Height:_____ Weight:_____ Employer:_____Cel Phone:_____

Occupation:_____ Work Phone:_____

Policy holders' Date of Birth: _____

PLEASE CHECK YOUR PRESENT SYMPTOMS:

___Headache	___Mid Back Pain	___Underweight/Anorexia	___Tension
___Neck Pain	___Mid Back Stiffness	___Muscle Jerking	___Irritability
___Neck Stiffness	___Low Back Pain	___Muscle Spasms	___Dizziness
___Memory Loss	___Leg Pain (L/R)	___Muscle Soreness	___Fainting
___Shoulder Pain (L/R)	___Leg Tingling (L/R)	___Blurred Vision	___Difficulty Sleeping
___Shoulder Stiffness	___Leg Numbness (L/R)	___Buzzing/Ringing in Ears	___Difficulty Breathing
___Arm Tingling (L/R)	___Overweight / Obesity	___Fatigue	___Crying Spells
___Arm Numbness (L/R)	___Depression	___Other? _____	

When did you first notice this / these problems? _____
Was it caused by: ____Auto Accident ___On The Job Injury ____Other?_____
Please describe accident: _____
Have you been treated for this condition before? _____ If yes, when? _____
Are you currently treating with another doctor: _____ If yes, whom? _____ For what?_____

LIST ALL PREVIOUS OPERATIONS, ILLNESSES, INJURIES AND HOSPITALIZATIONS:

(USE BACK OF SHEET IF MORE SPACE IS NEEDED)

Area of Body:	Date:	Describe:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any medications (over the counter or prescription)? _____ If yes, what and why? _____
_____
_____

SYSTEM REVIEW (PLEASE CHECK ANY SYMPTOMS OR CONDITIONS YOU HAVE OR HAVE HAD):

___Allergies	___Circulatory Problems	___Emphysema	___Low Blood Pressure
___Anemia	___Cold Feet or Hands	___Epilepsy	___Nausea
___Arthritis	___Constipation	___Heart Disease	___Osteoporosis
___Asthma	___Currently Pregnant	___High Blood Pressure	___Stroke
___Cancer	___Diabetes	___Kidney Infection	___Tuberculosis
___Chest Pain	___Ear Disorder	___Kidney Stones	___Vomiting

___Other: _____

Please explain any checked items from above:_____
_____
Do you smoke? _____ If yes, how much?_____ Do you exercise? _____ If yes, how much?_____
Are you on any special diets? _____ If yes, please describe:_____

I authorize the release of any information to assist with any insurance payments. Please sign and date below to acknowledge that the above information is to the best of your ability true and correct.

Patient/Guardian Signature:_____ **Date:**_____