AGADA
PHYSICAL THERAPY & INTEGRATIVE HEALTH CENTER

Date: _____ Name: _____
DOB: _____ Acct: _____
Insurance: _____

Patient Health History and Information

Date: ___/___/___ **Age:** _____ **Height:** _____ **Weight:**_____ **Dominant hand:** R L **Could you be or are you pregnant:** Yes No

Sex: M F **Reason for Therapy:**_____

Please describe how your injury/problem occurred (i.e. fall, activity, work, auto, unknown)**:**_____

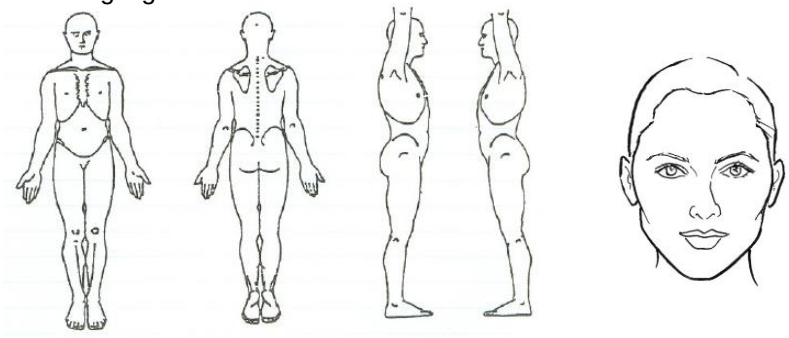
Date of injury or onset of symptoms: ___/___/___ **Recent surgery?** Yes No **Date:** ___/___/___ **Type:**_____

Please list any treatment you have received for this condition (i.e. Therapy, Chiropractor)**:**_____

For this condition have you had any of the following? None X-ray ___/___/___ MRI / CT scan ___/___/___

Injection: type: _____ ___/___/___ Surgery: type:_____ ___/___/___ Other:_____ ___/___/___

Using the key below indicate on the body diagrams where your symptoms are located.
X=Pain **//**= Numbness
O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe your pain/symptoms

Constant Intermittent Increasing
Decreasing Staying the same

Sharp Dull Aching Burning Numbness
Weakness Throbbing Other:_____

Which side are we seeing you for?: Right Left

What makes your symptoms worse? (i.e. heat, cold, rest, activity)_____

What makes your symptoms better? (i.e. heat, cold, rest, activity)_____

Please indicate your current limitations due to injury:

____ Sitting: _____ ____Standing: _____ ____Sleeping: _____
____ Going from sit to stand ____ Walking _____ ____ Lying down ____ Up/Down stairs
____ Reaching _____ ____ Squatting ____ Bending ____ Looking overhead
____ Taking a deep breath ____ Swallowing ____ Talking / Chewing / Yawning / All (circle one)
____ Turning head ____ Driving ____ Work
____ Self care / Hygiene _____ ____ Home activities _____
____ Repetitive activities _____ ____ Sports / Recreation _____
____ Other:_____

What are your goals for therapy?_____

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No	Unexplained weight change	Yes	No
Nausea / Vomiting	Yes	No	Night sweats / pain	Yes	No
Numbness genital/anal area	Yes	No	Problems with vision / hearing / speech	Yes	No
Dizziness / Fainting	Yes	No	Difficulty with bowel/bladder function	Yes	No
Unexplained weakness	Yes	No	Other:_____	Yes	No
Headaches	Yes	No			

Date:_____
Name:_____

Who referred you to Physical Therapy? _____

Primary Physician:_____

How did you hear about AGADA Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

GENERAL HEALTH HISTORY:

Have you had any falls or near falls in the past year? _____ Yes ____ No

Rate your overall health: Excellent Good Average Poor **Do you exercise?** Yes No _____x/week

List your recreational activities: _____

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No ____/week

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Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Living Situation: Alone Spouse Family Others

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____

Employer:_____ **Current work duty:** Full duty Restricted duty **Work days missed:** _____

QRC (if you have one)**:**_____

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Cancer	Self	Family	No	Thyroid problems	Self	Family	No
High blood pressure	Self	Family	No	Epilepsy/dizziness	Self	Family	No
Heart trouble/angina	Self	Family	No	Tuberculosis	Self	Family	No
Diabetes	Self	Family	No	Anemia/blood disorder	Self	Family	No
Stroke	Self	Family	No	Multiple Sclerosis	Self	Family	No
Osteoporosis	Self	Family	No	Circular/vascular problems	Self	Family	No
Osteoarthritis	Self	Family	No	Chemical dependency	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Depression	Self	Family	No	AIDS/HIV	Self	Family	No
Headaches	Self	Family	No	Hepatitis	Self	Family	No
Bladder/bowel problems	Self	Family	No	Other:_____	Self	Family	No

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Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not effect your ability to benefit from physical therapy treatment: ___Yes ____No _____

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90days of last Medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____